

MONTANA LEGISLATIVE HISTORY

Chapter 606 19 93

Bill H _____ S 285 Original bill & history ☒ c

H. Committee on Human Services & Aging

Hearing Date(s) Mar 24 ☒ c

Mar 26 ☒ c

Mar 28 ☒ c

_____ ☐ c

Date Out

Mar 30
Mar 29 ☒ c

S. Committee on Public Health, Welfare & Safety

Hearing Date(s) Feb 10 ^{1:00 PM} ☒ c

Feb 15 — Feb 13 ^{6:30 PM} ☐ c

Feb 17 ☒ c

_____ ☐ c

_____ ☐ c

Feb 17 ☒ c

Did this bill originate in an interim committee? ☐ Yes ☐ No

Committee _____

Report _____

Conference Committee

Apr 16 ☒ c

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SB 285

INTRODUCED BY FRANKLIN, ET AL.

CREATE MONTANA HEALTH CARE AUTHORITY

2/01	INTRODUCED		
2/01	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
2/01	FIRST READING		
2/01	FISCAL NOTE REQUESTED		
2/10	HEARING		
2/10	FISCAL NOTE RECEIVED		
2/10	FISCAL NOTE PRINTED		
2/20	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/22	2ND READING PASSED	48	0
2/23	3RD READING PASSED	49	0
	TRANSMITTED TO HOUSE		
2/23	REFERRED TO HUMAN SERVICES & AGING		
2/23	FIRST READING		
3/02	REVISED FISCAL NOTE REQUESTED		
3/11	REVISED FISCAL NOTE RECEIVED		
3/13	REVISED FISCAL NOTE PRINTED		
3/24	HEARING		
3/30	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/30	ON MOTION RULES SUSPENDED TO ALLOW ON 2ND AND 3RD READING TOMORROW		
3/31	2ND READING CONCURRED	88	12
4/01	3RD READING CONCURRED	87	11
	RETURNED TO SENATE WITH AMENDMENTS		
4/06	2ND READING AMENDMENTS NOT CONCURRED	50	0
4/07	CONFERENCE COMMITTEE APPOINTED		
4/21	CONFERENCE COMMITTEE REPORT NO. 1		
4/22	2ND READING CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	48	0
4/22	3RD READING CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	48	0
	HOUSE		
4/13	CONFERENCE COMMITTEE APPOINTED		
4/21	CONFERENCE COMMITTEE REPORT NO. 1		
4/22	2ND READING CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	86	12
4/22	3RD READING CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	85	14
4/28	SIGNED BY PRESIDENT		
4/28	SIGNED BY SPEAKER		
4/29	TRANSMITTED TO GOVERNOR		
5/03	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 606		
	EFFECTIVE DATE: 05/03/93—SECTIONS 1-20, & 44-47		
	EFFECTIVE DATE: 07/01/93—SECTIONS 30-34		
	EFFECTIVE DATE: 10/01/93—SECTIONS 29, 37-43		
	EFFECTIVE DATE: 01/01/94—SECTIONS 22-28, & 35-36		
	EFFECTIVE DATE: 07/01/96—SECTION 21		

SB 286

INTRODUCED BY DOHERTY

ALLOW FARM MUTUAL INSURERS TO INCLUDE LIABILITY PROVISION IN
INCORPORATION ARTICLES

2/01	INTRODUCED
2/01	REFERRED TO BUSINESS & INDUSTRY
2/01	FIRST READING
2/09	HEARING
2/09	TABLED IN COMMITTEE

SENATE BILL 285

Introduced by Franklin, et al.

2/01 Introduced
2/01 Referred to Public Health, Welfare & Safety
2/01 First Reading
2/01 Fiscal Note Requested
2/10 Hearing
2/10 Fiscal Note Received
2/10 Fiscal Note Printed
2/20 Committee Report--Bill Passed as Amended
2/22 2nd Reading Passed
2/23 3rd Reading Passed

Transmitted to House
2/23 Referred to Human Services & Aging
2/23 First Reading
3/02 Revised Fiscal Note Requested
3/11 Revised Fiscal Note Received
3/13 Revised Fiscal Note Printed
3/24 Hearing
3/30 Committee Report--Bill Concurred as Amended
3/30 On Motion Rules Suspended to Allow on
2nd and 3rd Reading Tomorrow
3/31 2nd Reading Concurred
4/01 3rd Reading Concurred

Returned to Senate with Amendments
4/06 2nd Reading Amendments Not Concurred
4/07 Conference Committee Appointed
4/21 Conference Committee Report No. 1
4/22 2nd Reading Conference Committee
Report No. 1 Adopted
4/22 3rd Reading Conference Committee
Report No. 1 Adopted

House
4/13 Conference Committee Appointed
4/21 Conference Committee Report No. 1
4/22 2nd Reading Conference Committee
Report No. 1 Adopted

4/22 3rd Reading Conference Committee
Report no. 1 Adopted

4/28 Signed by President

4/28 Signed by Speaker

4/28 Transmitted to Governor

5/03 Signed by Governor

Chapter Number 606

Effective Date: 05/03/93--Sections 1-20,
& 44-47

Effective Date: 07/01/93--Sections 30-34

Effective Date: 10/01/93--Sections 29,
37-43

Effective Date: 01/01/94--Sections 22-28,
& 35-36

Effective Date: 07/01/96--Section 21

1 *Sen. Smith* BILL NO. *285* *Franklin B. Brown*
 2 INTRODUCED BY *Franklin B. Brown*
 3 *Blaylock* *Mercer* *Copp* *Spencer* *Geisinger* *Cobb* *Wilson*
 4 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 5 HEALTH CARE ACCESS, HEALTH CARE PLANNING AND COST
 6 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 7 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 8 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
 9 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 10 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
 11 REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON
 12 LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH
 13 PLANNING REGIONS AND BOARDS; PROVIDING FOR THE POWERS AND
 14 DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
 15 UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH
 16 INSURANCE REFORM; TRANSFERRING TO THE AUTHORITY CERTAIN
 17 FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND
 18 ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS;
 19 AMENDING SECTION 50-15-101, MCA; AND PROVIDING EFFECTIVE
 20 DATES."

STATEMENT OF INTENT

23 A statement of legislative intent is required for this
 24 bill because [section 10] requires the Montana health care
 25 authority to adopt rules establishing a maximum of five

1 health care planning regions, to establish regional health
 2 care planning boards within those regions, and to establish
 3 a procedure for selection of regional board members. The
 4 legislature intends that the rules establishing the health
 5 care planning regions be based primarily upon the geographic
 6 health care referral patterns by which health care providers
 7 refer patients to specialists or larger health care
 8 facilities. These rules should also consider communication
 9 and transportation patterns and natural barriers to these
 10 patterns. The rules establishing the boards must specify the
 11 number of members, any relevant qualifications, and the
 12 operations and duties of the boards and must provide for a
 13 funding mechanism by grant from the authority. The procedure
 14 for selection of the board members must provide for public
 15 notice of the selection process.

16 A statement of intent is also required because [section
 17 12] requires the authority to adopt rules relating to the
 18 unified health care data base. The authority's rules must
 19 specify in comprehensive detail what information is required
 20 to be provided by health care providers and the times at
 21 which the information is to be provided. The rules must also
 22 provide for audit procedures to determine the accuracy of
 23 the filed data. The confidentiality provisions must be
 24 consistent with other state laws governing the
 25 confidentiality of public records, including medical

records, and must apply to employees of the authority and to others receiving or using records in the data base.

A statement of intent is also required because [section 13] requires the commissioner of insurance to adopt rules governing small employer group health plans. In determining the basic benefits package, the commissioner shall make objective determinations, supported by available data, concerning the type of benefits required and shall determine that the benefits to be required are cost-effective.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Montana health care authority

-- allocation -- membership. (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members appointed by the governor as follows:

(a) Within 30 days of [the effective date of this section], the majority and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment

to the authority.

(b) Within 30 days of [the effective date of this section], the majority and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and

1 rehabilitation services and the department of health and
2 environmental sciences are nonvoting, ex-officio members of
3 the authority.

4 **NEW SECTION. Section 2. Definitions.** For the purposes
5 of [sections 2 through 13], the following definitions apply:

6 (1) "Authority" means the Montana health care authority
7 created by [section 1].

8 (2) "Board" means one of the regional health care
9 planning boards created pursuant to [section 10].

10 (3) "Data base" means the unified health care data base
11 created pursuant to [section 12].

12 (4) "Health care facility" means all facilities and
13 institutions, whether public or private, proprietary or
14 nonprofit, that offer diagnosis, treatment, and inpatient or
15 ambulatory care to two or more unrelated persons. The term
16 includes all facilities and institutions included in
17 50-5-101(19). The term does not apply to a facility operated
18 by religious groups relying solely on spiritual means,
19 through prayer, for healing.

20 (5) "Health insurer" means any health insurance
21 company, health maintenance organization, insurer providing
22 disability insurance as described in 33-1-207, and, to the
23 extent permitted under federal law, any administrator of an
24 insured, self-insured, or publicly funded health care
25 benefit plan offered by public and private entities.

1 (6) "Health care provider" or "provider" means a person
2 who is licensed, certified, or otherwise authorized by the
3 laws of this state to provide health care in the ordinary
4 course of business or practice of a profession.

5 (7) "Management plan" means the health care resource
6 management plan required by [section 6].

7 (8) "Region" means one of the health care planning
8 regions created pursuant to [section 10].

9 (9) "Statewide plan" means one of the statewide
10 universal health care access plans for access to health care
11 required by [section 4].

12 **NEW SECTION. Section 3. Administration of health care**
13 **authority -- reports -- compensation.** (1) The authority
14 shall employ a full-time executive director who shall
15 conduct or direct the daily operation of the authority. The
16 executive director is exempt from the application of
17 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through
18 2-18-1013 and serves at the pleasure of the authority. The
19 executive director shall prepare plans and options for
20 consideration by the authority and implement plans as
21 directed by the authority.

22 (2) The authority may employ professional and support
23 staff necessary for the conduct of the business of the
24 authority and the business of the boards and may employ
25 consultants for the provision of services necessary to

1 fulfill the duties of the authority under [sections 2
2 through 13].

3 (3) The authority shall report to the legislature and
4 the governor at least twice a year on its progress since the
5 last report in fulfilling the requirements of [sections 2
6 through 13]. Reports may be provided in a manner similar to
7 5-11-210 or in another manner determined by the authority.

8 (4) Members of the authority must be paid and
9 reimbursed as provided in 2-15-124.

10 (5) The authority shall make grants to the boards for
11 the operation of the boards. The authority shall provide for
12 uniform procedures for grant applications and budgets of the
13 boards.

14 NEW SECTION. Section 4. Statewide universal health
15 care access plans required. On or before October 1, 1994,
16 the authority shall submit a report to the legislature that
17 contains the authority's recommendation for a statewide
18 universal health care access plan based on a single payor
19 concept and a recommendation for a statewide universal
20 access plan based on a regulated multiple payor concept.
21 Each statewide plan must guarantee access to health care
22 services for residents of Montana by making available a
23 uniform system of health care benefits. Each statewide plan
24 must contain the features required by this section and
25 [sections 5 through 8].

1 NEW SECTION. Section 5. Cost containment. (1) The
2 statewide plans must contain a cost containment component.
3 Except as otherwise provided in this section, each statewide
4 plan must establish a target for cost containment so that by
5 1999, the annual average percentage increase in statewide
6 health care costs does not exceed the average annual
7 percentage increase in the gross domestic product, as
8 determined by the U.S. department of commerce, for the 5
9 preceding years.

10 (2) The authority may modify the target required in
11 subsection (1) to take into account such factors as
12 population increases or decreases, demographic changes,
13 costs beyond the control of health care providers, and other
14 factors that the authority considers significant.

15 (3) The authority shall include the following features
16 in the cost containment component:

17 (a) global budgeting for all health care spending;

18 (b) a system for limiting demand of health care
19 services and controlling unnecessary and inappropriate
20 health care. The system may include prioritization of
21 services that allows for consideration of an individual
22 patient's prognosis.

23 (c) a system for reimbursing health care providers for
24 services and health care items. The reimbursement system
25 must provide that all payors, public or private, pay the

1 same rate for the same health care services and items and
2 that reimbursement for services is based predominantly upon
3 the health care service provided rather than upon the
4 discipline of the health care provider.

5 (d) a method of monitoring compliance with the target
6 required in subsection (1);

7 (e) expenditure targets for health care providers;

8 (f) disincentives for exceeding the targets established
9 pursuant to subsection (3)(e), including reduction of
10 reimbursement levels in subsequent years;

11 (g) reimbursement of health care providers and health
12 care facilities that is based upon negotiated annual budgets
13 or fees for services; and

14 (h) a plan by the authority, health care providers, and
15 health care facilities to educate the public concerning the
16 purpose and content of the statewide plans.

17 NEW SECTION. Section 6. Health care resource
18 management plan. (1) Each statewide plan must contain a
19 health care resource management plan. The management plan
20 must provide for the distribution of health care resources
21 within the regions established pursuant to [section 10] and
22 within the state as a whole, consistent with the principles
23 provided in subsection (2).

24 (2) The management plan must:

25 (a) be prepared by the authority after consideration of

1 regional management plans submitted to the authority
2 pursuant to [section 11];

3 (b) allow the authority to address individual needs of
4 each region, including such matters as the needs of Indian
5 tribes within the region, population increases or decreases,
6 and other demographic factors that the authority considers
7 significant;

8 (c) include incentives to improve access to health care
9 in underserved areas, including:

10 (i) a system by which the authority may identify
11 persons with an interest in becoming health care
12 professionals and provide or assist in providing health care
13 education for those persons; and

14 (ii) tax credits and other financial incentives to
15 attract and retain health care professionals in underserved
16 areas;

17 (d) include incentives to improve access to and use of
18 preventive care; primary care services, including mental
19 health services; and community-based care;

20 (e) include incentives for healthy lifestyles; and

21 (f) be biennially reviewed by the authority and be
22 amended as necessary.

23 NEW SECTION. Section 7. Health care billing
24 simplification. (1) Each statewide plan must contain a
25 component providing for simplification and reduction of the

1 costs associated with health care billing. In designing this
2 component, the authority may consider:

3 (a) conversion from paper health care claims to
4 standardized electronic billing;

5 (b) creating a claims clearinghouse, consisting of a
6 state agency or private entity, to receive claims from all
7 health care providers for compiling, editing, and submitting
8 the claims to payors; and

9 (c) requiring use of uniform claim forms and uniform
10 reporting of health care information.

11 (2) The health care billing component must include a
12 method to educate and assist health care providers and
13 payors who will use any health care billing simplification
14 system recommended by the authority.

15 (3) The billing component must provide a schedule for a
16 phasein of any health care billing simplification system
17 recommended by the authority. The schedule must relieve
18 health care providers, payors, and consumers of undue
19 burdens in using the system.

20 **NEW SECTION. Section 8. Other matters to be included**
21 **in statewide plans.** (1) The statewide plans recommended by
22 the authority must include:

23 (a) stable financing methods, including sharing of the
24 costs of health care by health care consumers on an
25 ability-to-pay basis through such mechanisms as copayments

1 or payment of premiums;

2 (b) a procedure for evaluating the quality of health
3 care services;

4 (c) public education concerning the statewide plans
5 recommended by the authority; and

6 (d) phasein of the various components of the plans.

7 (2) (a) In order to reduce the costs of defensive
8 medicine, the authority shall:

9 (i) conduct a study of tort reform measures, including
10 limitations on the amount of noneconomic damages, mandated
11 periodic payments of future damages, and reverse sliding
12 scale limits on contingency fees; and

13 (ii) propose any changes, including legislation, that it
14 considers necessary, including measures for compensating
15 victims of tortious injuries.

16 (b) As part of its study, the authority may consider
17 changes in the Montana Medical Legal Panel Act.

18 (c) The recommendations of the authority must be
19 included in its report containing the statewide plans.

20 (3) The authority shall conduct a study of the impacts
21 of federal and state antitrust laws on health care services
22 in the state and make recommendations, including
23 legislation, to address those laws and impacts. The
24 authority shall include in its plans legislation that will
25 enable health care providers or consumers, or both, to

negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

NEW SECTION. Section 9. Long-term care study and recommendations. The authority shall conduct a study of the long-term care needs of state residents and report to the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on its report in each region established under [section 10]. The authority shall present its report to the legislature on or before January 1, 1997.

NEW SECTION. Section 10. Health care planning regions and regional planning boards created -- selection -- membership. (1) The authority shall by rule establish within

the state a maximum of five health care planning regions that consist of counties or parts of counties, or both. Regions must be established based principally upon the geographic health care patterns of referral by which health care providers refer patients to specialists of health care facilities for more complex care. Each area of the state must be part of a region.

(2) Within each region, the board shall establish by rule a regional health care planning board. Each board must have five members and must include individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care.

(3) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select five members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(4) Regional board members serve 4-year terms, except that of the board members initially selected, one member serves for 2 years, two members serve for 3 years, and two members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve

1 a 4-year term. Board members must be compensated and
2 reimbursed in accordance with 2-15-124.

3 NEW SECTION. **Section 11.** Duties of boards. A board
4 shall:

5 (1) meet at the time and place designated by the
6 presiding officer, but not less than quarterly;

7 (2) submit an annual budget and grant application to
8 the authority at the time and in the manner directed by the
9 authority;

10 (3) adopt procedures governing its meetings and other
11 aspects of its day-to-day operations as the board determines
12 necessary;

13 (4) establish a process to determine health care needs
14 of the region;

15 (5) advise the authority concerning all health care
16 needs of the region relating to the creation and
17 implementation of the statewide plan;

18 (6) submit to the authority a regional management plan
19 providing for allocation of health care resources within the
20 region, including allocation of resources in underserved
21 areas;

22 (7) establish a mechanism for determining and
23 considering the health care needs of Indian tribes within
24 the region; and

25 (8) conduct at least one annual public hearing to

1 provide for public participation in the development of the
2 regional management plan.

3 NEW SECTION. **Section 12.** Health care data base --
4 information submitted -- enforcement. (1) The authority
5 shall develop and maintain a unified health care data base
6 that enables the authority, on a statewide basis, to:

7 (a) determine the distribution and capacity of health
8 care resources, including health care facilities, providers,
9 and health care services;

10 (b) identify health care needs and direct statewide and
11 regional health care policy to ensure high-quality and
12 cost-effective health care;

13 (c) conduct evaluations of health care procedures and
14 health care protocols; and

15 (d) compare costs of various health care procedures in
16 one location of providers and health care facilities with
17 the costs of the same procedures in other locations of
18 providers and health care facilities.

19 (2) The authority shall by rule require health care
20 providers, health insurers, and health care facilities,
21 private entities, and entities of state and local
22 governments to file with the authority the reports, data,
23 schedules, statistics and other information determined by
24 the authority to be necessary to fulfill the purposes of the
25 data base provided in subsection (1). Material to be filed

1 with the authority may include health insurance claims and
2 enrollment information used by health insurers.

3 (3) The authority may issue subpoenas for the
4 production of information required under this section and
5 may issue subpoenas for and administer oaths to any person.
6 Noncompliance with a subpoena issued by the authority is,
7 upon application by the authority, punishable by a district
8 court as contempt pursuant to Title 3, chapter 1, part 5.

9 (4) The data base must:

10 (a) use unique patient and provider identifiers and a
11 uniform coding system identifying health care services; and

12 (b) reflect all health care utilization, costs, and
13 resources in the state and the health care utilization and
14 costs of services provided to Montana residents in another
15 state.

16 (5) Information in the data base required by law to be
17 kept confidential must be maintained in a manner that does
18 not disclose the identity of the person to whom the
19 information applies.

20 (6) The authority shall adopt by rule a confidentiality
21 code to ensure that information in the data base is
22 maintained and used according to state law governing
23 confidential health care information.

24 (7) The duties of the authority under this section may
25 not be construed to allow the authority to use the data base

1 to manage a corporate health care facility in a manner that
2 usurps the appropriate powers of the board of directors of
3 the facility.

4 NEW SECTION. Section 13. Small employer group health
5 insurance reform. (1) As used in this section, the following
6 definitions apply:

7 (a) "Health plan" or "plan" means the plan specified in
8 the rules adopted pursuant to subsection (2).

9 (b) "Person" means an individual, corporation, firm,
10 partnership, sole proprietorship, or other business entity.

11 (c) "Small employer" means a person employing at least
12 3 but not more than 25 employees.

13 (2) The commissioner of insurance shall adopt rules
14 specifying the health care benefits to be included in health
15 care plans offered by small employers.

16 (3) A health insurer who offers a health plan to a
17 small employer in Montana shall offer the same health plan
18 to other small employers in Montana and shall allow
19 continuous open enrollment in that plan.

20 (4) A health insurer who offers a health plan may not
21 limit preexisting conditions for a period longer than 6
22 months after the effective date of coverage under the plan.

23 (5) A health insurer may not cancel, refuse to issue,
24 or refuse to renew coverage under a health plan for any
25 reason other than nonpayment of premiums or fraud or

1 material misrepresentation by the insured in the application
2 for coverage under the plan.

3 (6) A health insurer shall provide notice to an insured
4 of the terms of renewal of coverage under a health plan at
5 least 10 days before the expiration of the coverage. The
6 terms upon which coverage under the plan is offered to the
7 insured for renewal may not be any less favorable, with
8 respect to all provisions, including benefits but excluding
9 premium rates and minor administrative changes, than the
10 terms of the coverage about to expire.

11 (7) A health insurer may not charge a higher premium
12 for renewal of coverage under a health plan than for initial
13 coverage under the same plan.

14 (8) A health insurer shall renew coverage under a
15 health plan for not less than 12 months.

16 (9) A health insurer may not require an insured or a
17 person applying for coverage under a health plan with that
18 insurer to comply with limitations in a health plan
19 concerning preexisting conditions if that insured or person
20 has previously satisfied preexisting condition requirements
21 of another health insurance policy or plan offering
22 substantially similar benefits.

23 (10) Except as provided in subsection (11), all health
24 insurers shall establish a single rating scheme that is
25 applied consistently for health plans and does not

1 discriminate between persons as to the amount of the premium
2 based upon differences in sex, health status, employment, or
3 geographic location.

4 (11) (a) The commissioner of insurance shall adopt by
5 rule standards and a procedure to allow health insurers to
6 use one or more risk classifications in establishing their
7 rating system. The rating system may not contain a rate
8 spread greater than 30% of the median rate or less than 30%
9 of the median rate.

10 (b) The commissioner shall phase in the requirements of
11 subsection (10) and this subsection as the commissioner
12 considers appropriate.

13 (c) By July 1, 1995, a premium rate may not exceed 125%
14 of the premium rate for the least expensive group.

15 (12) On [6 months from the effective date of this
16 subsection] the commissioner of insurance shall adopt rules
17 implementing this section. The rules adopted by the
18 commissioner become effective on [1 year from the effective
19 date of this subsection].

20 NEW SECTION. **Section 14.** vital statistics transferred
21 to authority. (1) The functions of the board of health and
22 environmental sciences and the department of health and
23 environmental sciences contained in Title 50, chapter 15,
24 concerning vital statistics are transferred to the Montana
25 health care authority created in [section 1].

(2) The code commissioner shall change references to "department of health and environmental sciences" or "department" (of health and environmental sciences) and "board of health and environmental sciences" or "board" (of health and environmental sciences) to "authority" and shall make other changes in grammar consistent with the purpose of this section.

Section 15. Section 50-15-101, MCA, is amended to read:

"50-15-101. Definitions. Unless the context requires otherwise, in parts 1 through 4 the following definitions apply:

(1) "Board Authority" means the ~~board--of--health--and environmental--sciences~~ Montana health care authority provided for in ~~2-15-2104~~ [section 1].

(2) "Dead body" means a lifeless human body or parts of a body from which it reasonably may be concluded that death occurred recently.

~~{3}--"Department"--means--the--department--of--health--and environmental--sciences--provided--for--in--Title--27--chapter--15, part--21--~~

~~{4}{3}~~ (3) "Dissolution of marriage" means a marriage terminated pursuant to Title 40, chapter 4, part 1.

~~{5}{4}~~ (4) "Fetal death" means a birth after 20 weeks of gestation, or before 20 weeks of gestation if the fetus weighs more than 500 grams at the time of delivery, that is

not a live birth.

~~{6}{5}~~ (5) "Invalid marriage" means a marriage decreed by a district court to be invalid for the reasons contained in 40-1-402.

~~{7}{6}~~ (6) "Live birth" means the birth of a child who shows evidence of life after being entirely outside the mother.

~~{8}{7}~~ (7) "Local registrar" means a person appointed by the department to act as its agent in administering this chapter in the area set forth in the letter of appointment.

~~{9}{8}~~ (8) "Person in charge of interment" means a person who places or causes to be placed a dead body or the ashes after cremation in a grave, vault, urn, or other receptacle or otherwise disposes of the body.

~~{10}{9}~~ (9) "Physician" means a person legally authorized to practice medicine in this state.

~~{11}{10}~~ (10) "Vital statistics" includes the registration, preparation, transcription, collection, compilation, and preservation of data pertaining to births, adoptions, legitimations, deaths, fetal deaths, marital status, and incidental supporting data."

NEW SECTION. Section 16. Effective dates. (1) [Sections 1 through 12, 13(10) through (12), 14, 15, and this section] are effective on passage and approval.

(2) [Section 13(1) through (9)] is effective [1 year

1 from the date of passage and approval of this act).

2 NEW SECTION. **Section 17.** Codification instruction. (1)

3 [Section 1] is intended to be codified as an integral part
4 of Title 2, chapter 15, and the provisions of Title 2,
5 chapter 15, apply to [section 1].

6 (2) [Sections 2 through 13] are intended to be codified
7 as an integral part of Title 50, and the provisions of Title
8 50 apply to [sections 2 through 13].

-End-

STATE OF MONTANA - FISCAL NOTE

Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0285, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION: An act providing for universal health care access, health care planning and cost containment; creating the Montana Health Care Authority, providing for the powers and duties of the authority; requiring a statewide universal health care access plan; requiring a health care resource management plan; providing for simplification of health care expenses billing; requiring the authority to conduct a study and report on long-term care; requiring the authority to establish health planning regions and boards; providing for the powers and duties of regional boards; requiring the establishment of a unified health care data base; providing for health insurance reform; and transferring to the authority certain functions of the department and board of health and environmental sciences relating to vital statistics.

ASSUMPTIONS:**Montana Health Care Authority**

1. During the 1995 biennium, the Montana Health Care Authority (MHCA) will focus predominately on development of a health care database, analysis of patterns of health care utilization and cost, policy development, and development of specific health plans for presentation to the 1995 legislative session.
2. Development of the organization structure necessary to fulfill the responsibilities of the MHCA will occur as soon as possible after passage of the bill. The executive director and board secretary will be hired as soon as possible upon passage.
3. Due to the complexity of health care issues, the MHCA will require significant technical assistance on a wide variety of issues impacting the different sectors of health care including the general field of medicine, health care reform, legal ramifications of medical malpractice issues, substantial actuarial data collection and analysis, medical technology, and complex health data system. In order to give the MHCA the flexibility to analyze the staffing needs of the Authority and identify those services that could most efficiently be provided through contracts, the majority of funds are allocated to operating expenses with the understanding that the MHCA would have the option to hire such staff as deemed necessary and appropriate.
4. The five appointed members of the Health Care Authority serve as volunteers and are not state employees.
5. There will be five regional boards. All regional board members are volunteers and are not state employees.
6. The MHCA and regional boards will conduct at least six meetings per year during the first two years.
7. Travel and per diem for regional boards is included in the operating expenses of the MHCA.
8. It is anticipated that grant funds from the Robert Wood Johnson Foundation will be available to assist the MHCA in the development of the statewide health care database.
9. To the extent that MHCA activities are directly related to the state's Medicaid program, such expenditures could be matched for federal funds at a ratio of 50% state and 50% federal funds.
10. The Vital Statistics Bureau will be transferred intact to the Health Care Authority. Existing bureau expenditures and revenues will remain, but are not included in this fiscal note. If the Vital Statistics Bureau were physically moved there would be costs related to that move we are unable to estimate.

(Continued)

Dave Lewis 2-9-93
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Eve Franklin 2/10/93
EVE FRANKLIN, PRIMARY SPONSOR DATE
Fiscal Note for SB0285, as introduced

SB 285

State Auditor's Office

1. The Insurance Commissioner will adopt rules for benefit plans.
2. The Insurance Commissioner will review rates.
3. The Insurance Commissioner will adopt rules for risk classification and rating.
4. Staff will not be hired until the start of FY94 even though part of the bill's responsibilities are initiated upon passage and approval. Two FTE would be hired; one Grade 15 @ \$32,817/year and an actuary @ \$74,400/year.

FISCAL IMPACT:

<u>Montana Health Care Authority</u>	<u>FY '94</u>			<u>FY '95</u>		
	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>
FTE	0	2.00	2.00	0	2.00	2.00
Personal services	0	93,921	93,921	0	93,921	93,921
Operating expenses	0	<u>656,079</u>	<u>656,079</u>	0	<u>656,079</u>	<u>656,079</u>
Total	0	750,000	750,000	0	750,000	750,000

<u>Expenditures:</u>						
General Fund*	0	750,000	750,000	0	750,000	750,000

* Ignores potential use of federal and foundation funds per assumptions 8 and 9.

<u>State Auditor's Office</u>	<u>FY '94</u>			<u>FY '95</u>		
	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>
Personal Services	0	\$107,217	\$107,217	0	\$107,217	\$107,217
Operating Costs	0	35,600	35,600	0	35,600	35,600
Equipment	0	<u>2,568</u>	<u>2,568</u>	0	<u>0</u>	<u>0</u>
Total	0	\$145,385	\$145,385	0	\$142,817	\$142,817

Expenditures:

In order to implement this bill, additional general fund expenditures in the amount of \$145,385 and \$142,817 will be required in the coming biennium.

TECHNICAL NOTES:

Revenues and expenditures related to the Vital Records and Statistics Bureau will be incorporated into the Health Care Authority. These figures are not included under fiscal impact.

SENATE BILLS STATUS SHEET

COMMITTEE

BILL NUMBER	ENTERED COMMITTEE	CONSIDERED	OUT OF COMMITTEE	DP DO PASS	DNP DO NOT PASS	DPAA DO PASS AS AMENDED	DNPA DO NOT PASS AS AMENDED
SB 166	1/16	2/1	2/15			X	
SB 177	1/18	2/3	^{2/15} TABLED				
SB 187	1/18	1/22	1/26			X	
SB 209	1/19	1/25	1/26	X			
SB 237	1/22	2/3	^{2/19} TABLED				
SB 262	1/27	2/8	^{2/19} TABLED				
SB 266	1/27	2/12	2/18			X	
SB 267	1/27	2/5	^{2/19} TABLED				
SB 285	2/1	2/10	2/20			X	
SB 290	2/1	2/8	^{2/19} TABLED				
SB 291	2/1	2/15	2/18			X	
SB 305	2/3	3/3	3/12			X	
SB 312	2/3	2/12	2/15	X			

MINUTES

**MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION**

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 10, 1993, at 1:00.

ROLL CALL

Members Present:

Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

Staff Present: Laura Turman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 285
Executive Action: None.

HEARING ON SB 285

Opening Statement by Sponsor:

Sen. Eve Franklin, Senate District 17, Great Falls, said SB 285 is an approach to health care based on a broad consensus. The Committee has already heard testimony on the need for health care reform, and the demand is understood. HealthMontana, SB 285, is the product of the Montana Citizen's Health Care Group, which does a number of specific things to bring Montana closer to health care reform. Sen. Franklin went over the structure of SB 285. (Exhibit #1) Single payor and multi-payor plans both must be based on the concepts of universal access to care, cost containment, data collection, regional participation, public participation, administrative simplification, tort reform and small employer insurance reform.

Proponents' Testimony:

Dr. Martin Burke, Chair of the Montana Citizen's Health Group, said this is a momentous occasion because of the nature of the coalition of people who have come together to develop and support SB 285. Democrats, Republicans, consumers and providers have come together to endorse this bill. Regarding the federal government's role, Montanans should resolve their own health care problems for a Montana solution, not a D.C. solution. President Clinton promised to give states flexibility in health care reform. Mr. Burke said there is no quick fix to Montana's health care problems. SB 285 will insure adequate health care for all Montanans, it will contain costs by establishing caps on health care expenditures and by imposing global budgeting, it will create a state wide Health Care Authority, it will create a central database, and it will require the simplification of billing. This bill is not "another study bill" and Mr. Burke urged the Committee to pass SB 285.

Sen. Bob Brown, Senate District 2, said he is a co-sponsor and proponent of SB 285. He said he also represents Sen. Bruce Crippen who was unable to attend the hearing. SB 285 is a recognition of a broad-based group of people that health care is a necessity just like food, shelter and clothing. SB 285 commits Montana to a comprehensive system of health care for all Montanans in 1995. The Health Care Authority will prepare both single payor and multi-payor options arrived at through a series of hearings which will further educate Montanans and the legislature of the avenues available.

Kathleen Anne Long, PhD, provided written testimony. (Exhibit #2)

Lawrence L. White, Jr., President of St. Patrick's Hospital in Missoula said St. Patrick's is committed to fashioning a reorganization of Montana's health care delivery system. Mr. White said it was significant to him that those who have different concerns about the health care problem arrived at the consensus in SB 285. For hospitals, the hard point is global budgeting, because there is a fear that this means government control. Global budgeting allows for accurate predictions of what health care will cost, and the Health Care Authority will have the flexibility to enact mechanisms of global budgeting consistent with the needs of Montana.

Dr. Bill Reynolds, Missoula, said he would address global budgeting from a physician's point of view. The American Board of Physicians and the Family Physicians Organization favor global budgeting. Without it, there will not be effective cost control. The major reason for the health care crisis is that cost of health care has accelerated too fast, and individuals and companies cannot afford it. With this kind of a crisis, tough measures such as global budgeting are necessary because it represents the only way to control the inflation in health care

costs. Dr. Reynolds said Montana is not an appropriate state for managed competition because of the low population, and yet global budget plans are shown to work.

Jeff Strickler, M.D., provided written testimony. (Exhibit #3)

David Forbes, pharmacist and Co-chair of the Montana Citizen's Health Group, said SB 285 requires the development and maintenance of unified database. It is important to have appropriate data to make appropriate decisions. Mr. Forbes said a central authority would be responsible for the coordination of data collection.

Gloria Paladichuk, Richland County Commissioner and member of the Montana Citizen's Health Group, provided written testimony. (Exhibit #4)

Dr. Kenneth Eden, Helena, provided written testimony. (Exhibit #5)

Margaret Fleming, retired manager of the Social Security Office in Kalispell, provided written testimony. (Exhibit #6)

Don Judge, Montana State AFL-CIO, provided written testimony. (Exhibit #7)

Doug Campbell, President of the Montana Senior Citizens Association, provided written testimony. (Exhibit #8)

Leesa Klesh, Program Director for Montana Farmers Union, provided written testimony. (Exhibit #9)

Donna Schramm, Registered Nurse and Administrator of the Montana Consortium for Excellence in Health Care, provided written testimony. (Exhibit #10)

Peter Blouke, Director of the Department of Social and Rehabilitation Services, said the actions taken now will have a profound impact on the burden to finance health care in the future. Mr. Blouke said he would present the Racicot Administration's support for SB 285. The reasons for this support are that funds to cover basic governmental operations now must be diverted to cover health care costs. It is the largest sector of the state's budget and there are over 140,000 uninsured citizens in Montana. It is imperative that reform proceed rationally. Before the state is committed to a definitive system of health care reform, data must be collected from all aspects of health care. SB 285 allows the time for the collection of such data, and it allows the structure and format which allows for public participation in sustainable health care reform. It contains the elements the Racicot Administration believes are essential for health care reform: universal access, basic health care for all Montanans, insurance reform, tort reform, administrative simplification, and mechanisms to contain the cost

of health care. The administration does not believe Montana can afford or support a single payor system, and supports a multi-payor system.

Michael Regnier, Montana People's Action, provided written testimony. (Exhibit #11)

Chuck Butler, Vice-President of Blue Cross and Blue Shield of Montana, provided written testimony. (Exhibit #12)

Christine Mangiantini, League of Women Voters, said SB 285 allows for extensive public participation in the form of public hearings and public education programs concerning the content of the state-wide health care program. Also, the Health Care Authority will have the ability to address the needs of different regions, including Native Americans. It allows the Health Care Authority to recommend legislation. Ms. Mangiantini focuses on the health care needs of all of Montana's citizens, and the League urges the Committee do pass SB 285.

Suzi Holt, Medical Librarian at Shodair Hospital in Helena, said she represents the Task Force on Biomedical Information. Ms. Holt provided a copy of the Task Force's Report to the Governor. (Exhibit #13) For adequate health care for all Montanans, access to current medical knowledge must be insured for all health care providers. The Report documents that this access to knowledge can avoid unnecessary tests, procedures, hospitalization, and can provide inexpensive, preventative medicine to avoid malpractice suits. They found that information resources are concentrated in the state's population centers, and 35% of Montana's physicians are not affiliated with a health care library. Without state-wide leadership, there is no ability to plan growth of these services.

Kate Cholewa, Montana Women's Lobby, said they believe that a single payor system is the best way to solve the health care problems of Montana, but they do support SB 285. The Women's Lobby suggests the bill be amended so the Regional Boards and the five member Authority reflect the gender and race make-up of the state.

John Ritter, Past President of the Montana Medical Association, said SB 285 is an excellent start to restructuring health care in Montana. Mr. Ritter said there should be amendments to clarify the intent, which is to provide all citizens of the state with good health care. He went over Amendments 1 and 2. (Exhibit #14) They do not want this bill to be limiting to non-mainstream providers, or to the amount of money spent by private citizens on the care they wish to seek.

Dr. Jack McMahon, Helena, addressed Amendments 3-5 from the Montana Medical Association. (Exhibit #14) Dr. McMahon said there are concerns that the Medicare and Medicaid systems are not paying their share of costs. He strongly urged the Committee to

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

February 10, 1993

Page 5 of 9

support SB 285.

Dr. Nelson, Obstetrician from Kalispell, said he would like the Committee to take a look at SB 267 as it presents regional health care planning. He asked the Committee consider the National Association of Insurance Commissioners' small group insurance reform, and the implementation of the single billing system presented in SB 267 which will be on line by January 1, 1994. Regarding global budgeting, there must be assurances from the federal government that there will be continuation of the Medicaid match and Medicare match. Dr. Nelson proposed that the Montana Legislature send a resolution to the Montana Congressional Delegation that Montana receive a waiver to keep all Social Security employee contributions to Medicare, Part A and Part B. Senior citizens can save money, and it can go towards care for Montana's uninsured.

Wally Hinkelman, Montana Nurses Association, provided written testimony. (Exhibit #15)

Cal Winslow, Deaconess Medical Center in Billings, said SB 285 is at the level of public dialogue, and he supports it.

Larry Akey, Montana Association of Life Underwriters, provided written testimony (Exhibit #16) and amendments. (Exhibit #17)

Steve Turkiewicz, Executive Secretary of MADA Insurance Trust, representing the Montana Association of Health Care Purchasers said they support SB 285.

Riley Johnson, National Federation of Independent Businesses, said the Federation supports SB 285.

Jamie Doggett, Montana Cattlemen and Montana Farm Bureau, said they support SB 285.

Paulette Kohman, Executive Director of the Montana Council for Maternal and Child Health, said universal health care is on their agenda, and they'll support SB 285.

Tom Ebzery, St. Vincent Hospital in Billings, said SB 285 is an "admirable beginning."

Staci Riley, Montana Federation of State Employees and the Montana Federation of Health Care Employees, said they support SB 285 and urged a do pass recommendation.

Greg Eklund, Montana Democratic Party, provided written testimony. (Exhibit #18)

Russ Ritter, Washington Corporation, said they support SB 285.

Bill Olson, American Association of Retired Persons (AARP), provided written testimony. (Exhibit #19)

Clyde Dailey, Executive Director of the Montana Senior Citizens Association and Chair, Montanans for Universal Health Care, said he supports the concept of SB 285, and he would like to work further with the Committee.

Christian Mackay, Montanans for Universal Health Care, said they support SB 285. He urged the possibility of appointing a subcommittee to look at this issue more fully, and he looks forward to working with the Committee. He submitted written testimony. (Exhibit #20)

Chet Kinsey, Montana Senior Citizens Association, said they support SB 285, they believe that all individuals should be covered, in a single payor system, with a well-financed Authority, a regional committee and consumer involvement with those committees.

Mona Jamison, Montana Chapter of the American Physical Therapy Association, said they stand in strong support of SB 285, and they'd like to work with the Committee when Executive Action is taken.

Jim Ahrens, President of the Montana Hospital Association, provided written testimony (Exhibit #21), and provided testimony for Paul Hanson, Administrator of the Big Horn County Memorial Hospital and Nursing Home in Hardin. (Exhibit #22) Mr. Ahrens said John Guy, President of St. Peter's Hospital in Helena was here to testify but had to leave. He also provided amendments. (Exhibit #23)

Mary McCue, Montana Dental Association, said the Association supports SB 285.

Bonnie Tippy, Montana State Pharmaceutical Association and the Montana Chiropractic Association, said they support SB 285.

Dan Ritter, Montana Chamber, said they support SB 285.

Mark O'Keefe, State Auditor and Commissioner of Insurance, provided written testimony (Exhibit #24), and an amendment concerning small group insurance reform. (Exhibit #25)

Opponents' Testimony:

Dan Shea, Montana Low Income Coalition, said the Coalition has one objection to SB 285. They believe there should be mechanism for regulation of negotiation in the bill. They are also concerned about the low-level wages and lack of benefits for the individuals in the health care industry who work "at the bottom of the spectrum." These are the individuals who keep the institutions running. Mr. Shea said if these concerns were not met, these individuals are going to remain the working poor, and no one will be concerned about them.

Questions From Committee Members and Responses:

Sen. Christiaens asked how the Tribal Governments would be brought into this particular plan. Martin Burke said Greg DuMontier of the Salish-Kootenai Tribes is a member of the Montana Citizens Health Group. In the provisions for regional planning, there needs to be communication with the tribal councils of Montana. The Native Americans in Montana are residents of this state and are qualified for the benefits of the plan.

Sen. Mesaros asked Sen. Franklin how much control the Health Care Authority would have over global budgeting. Sen. Franklin said some global budgeting already occurs, with Medicare and Medicaid for example. In SB 285 there are alternatives so that one can opt for global budgeting or fee for service.

Dr. Bill Reynolds said allocations for next year's expenditures are put into a pot, and it's categorized, and so much can be spent but no more. If expenditures go over what is allocated, you do not receive it the following year. The certificate of need process approves what can be done. It is much more complicated to put a cap on fees. Prepaid health care also caps fees.

Dr. Jack McMahon, said the committee included in the global budgeting position a prioritization program by the public and legislative bodies. The major fear of physicians regarding global budgeting is that they would be asked to decide which patient, A or B, could receive surgery. One of the amendments he proposed would include payment for treatment which is proven to be effective. Dr. McMahon said people cannot expect to have all health care needs paid for.

Sen. Towe asked Martin Burke, if he were the chairman of the Montana Citizens Health Group. Mr. Burke said he was.

Sen. Towe said he had some questions comparing SB 267 and SB 285. Sen. Towe asked Mr. Burke if SB 285 had no prescription cost containment or disbursement mechanism. Mr. Burke said they do not specifically address drugs, but the Health Care Authority will have the right to address that issue when it develops plans for the 1994 Legislature.

Sen. Towe asked Mr. Burke if SB 285 had no reference to a certificate of need. Mr. Burke said that was correct, but the Health Care Authority will be charged by the Legislature to develop plans which address the problems associated with a certificate of need.

Sen. Towe asked Mr. Burke about anti-trust concerns addressed in

SB 267 which are not addressed in SB 285. Mr. Burke said that is not accurate, SB 285 makes reference to anti-trust because it is part of the package of legislation that would come forward. There must be anti-trust provisions.

Sen. Towe said that it was addressed more comprehensively in SB 267. Mr. Burke said it was addressed more comprehensively because SB 267 includes immediate implementation of that part of the bill.

Sen. Towe said SB 267 contains a provision for health bargaining groups, and SB 285 does not. Mr. Burke said that was correct, but there is nothing in SB 285 to prevent health bargaining groups.

Sen. Towe asked Mr. Burke if SB 267 contained provisions for health purchasing pools. Mr. Burke said there was nothing in SB 285 to prevent health purchasing pools, but there are some individuals who are convinced that does not solve much of the problem.

Sen. Towe said SB 267 contained a facilities planning and review panel and SB 285 does not. Mr. Burke said that was correct, but in terms of preparing for comprehensive health care planning for Montana, the review process must be addressed. With no centralized database, it would be impossible to put a review panel into place immediately.

Sen. Towe asked Mr. Burke if it were a possibility to put a review panel into SB 285. Mr. Burke said it could be put into place right now, but it would have to be integrated into the legislation which would be brought to the Legislature in 1994.

Sen. Towe said in SB 267 there was a provision for review of hospital budgets which is not directly in SB 285. Mr. Burke said global budgeting is a method of cost containment, and that mechanism will have to be "flushed out" by the Health Care Authority upon study of information.

Sen. Towe said he was most perplexed by SB 267, which defines a single payor system as providing Montanan residents with a uniform set of benefits. SB 285 mandates two proposals, a single payor and a multi-payor. On Page 7, Section 4, it states that "each state-wide plan must guarantee access to health care services for residents of Montana by making available a uniform system of health care benefits." Sen. Towe said that sounds like the SB 267 definition of a single payor system. Mr. Burke said there can be multiple payors, private insurance companies and the benefit package can be defined. Mr. Burke said that typically, the single payor system makes us think of a Canadian-style system, where there is only a governmental payor. There is nothing to prevent the development of a multi-payor system which provides a uniform benefit package to Montanans.

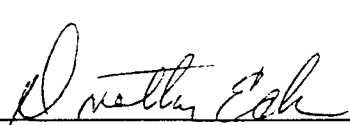
Chairman Eck said the Committee would reconvene at 6:30 for an informational meeting so that the Committee can continue with questions.

Closing by Sponsor:

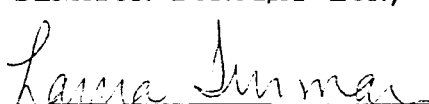
Sen. Franklin said that regarding prescription drugs, in SB 285 the term "health care items" covers prescription drugs. This language could be strengthened to make it more clear. Regarding the definition of "single payor" in SB 267, the argument could be made that that is a broad definition of "universal access." Sen. Franklin said both single and multi-payor systems provide those services. Therefore the mechanism is the difference, not the goal. Sen. Franklin said a tremendous amount of energy and faith went into the process of bringing SB 285 together. Sen. Franklin said there were some specific and substantive amendments brought fourth during the hearing, noting especially the amendments about insurance reform. Small group insurance reform is essentially interim reform because in two years, the Legislature will be addressing the multi-payor and single payor systems. The anti-trust amendments and the Montana Medical Association amendments would be looked at more closely, but the language in SB 285 does allow for flexibility.

ADJOURNMENT

Adjournment: Chairman Eck announced that the Health Care Caucus would meet Thursday, February 11th, in room 104 at noon. Chairman Eck adjourned the hearing.



SENATOR DOROTHY ECK, Chair



LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-10-92

[illegible]

COMMITTEE NO. 1
DATE 2-10-93
BILL NO. SB 285

S.285 - HEALTHMONTANA

Sponsored by Senator Eve Franklin

S.285 is based on the health reform proposal developed by the Montana Citizen's Health Group, which was organized by Senator Max Baucus

MONTANA HEALTH CARE AUTHORITY - A five-member health care Authority would be established to develop two health reform plans -- one using a single payer and one using multiple payers. Both plans must be submitted to the Montana Legislature no later than October 1994.

GUARANTEED HEALTH BENEFITS - All Montanans would be guaranteed a uniform set of comprehensive health benefits.

COST CONTROL - Costs would be controlled through a series of mechanisms designed to eliminate waste, promote fiscal discipline, and provide for better management of Montana's health resources. These measures include establishing an expenditure target for all health spending in Montana, eventually tying health spending increases to growth in general inflation and growth in the economy, reimbursing health providers according to predetermined fee schedules, and developing proposals for limiting demand.

DATA COLLECTION - The Authority would collect data to identify statewide health care needs and direct statewide and regional health care policy to ensure cost effective, high-quality health care.

REGIONAL PARTICIPATION - Five regional planning boards would be established to advise on all regional health needs as related to a statewide plan.

PUBLIC PARTICIPATION - To assure broad public participation, The Montana Health Care Authority and the Regional Planning Boards must hold public hearings in each health care region to receive oral and written comments from the public on the statewide proposals.

ADMINISTRATIVE SIMPLIFICATION - The Authority would propose measures to simplify the billing process for individuals and providers. This could include mandating the use of common claims forms and promoting electronic claims processing.

TORT REFORM - To reduce the cost of defensive medicine, the Authority would analyze malpractice law in Montana and propose changes as appropriate.

SMALL-EMPLOYER INSURANCE REFORM - No insurer in Montana would be able to deny or cancel coverage to any small business based on health status or a pre-existing health condition.

S. 285

Health Montana

SENATE HEALTH & WELFARE

EXHIBIT NO. 2

DATE 2-10-93

BILL NO. SB 285

Testimony of Kathleen Ann Long, PhD, RNCS

HEALTHMONTANA HEARING BEFORE THE PUBLIC HEALTH, WELFARE
AND SAFETY COMMITTEE OF THE MONTANA SENATE

February 10, 1993

Chairman

Good Afternoon. ~~Mr. Chairman~~ and honorable committee members, I am a registered nurse, certified for advanced practice nursing. For the past 12 years, I have been involved in direct patient care and nursing education in Montana. It was my privilege to serve as a co-chair of the Citizen's Committee which assisted in drafting the HealthMontana legislation.

I would like to speak to you about the cost containment aspects of the bill. The following background facts may be helpful to you as you consider the cost containment issue.

- In October, 1992, the Congressional Budget Office reported that lack of restraint in the health care industry, unless changed, will cost this nation \$1.7 trillion by the year 2000.

In 1965, health care costs consumed 6% of our Gross Domestic Product; that percent grew to 12 in 1990 and is projected to be 18% by the year 2000.

- If uncontrolled, national health care costs are anticipated to increase by \$500 billion between 1990 and 1995, and this will occur while over 60 million Americans are without adequate health care (National Leadership Coalition for Health Care Reform) -- a situation which ultimately results in tremendous social costs due to lost productivity and eventual reliance on social welfare programs.

- Despite these enormous expenditures, we do not have an enormously successful health care system. It is true that millions of persons receive highly sophisticated, technologically advanced health care. However, our health care is not fairly or equitably delivered; a fact which is readily apparent in many areas of Montana.

- In a recent comparison with ten other developed nations, the United States ranked last in the delivery of primary health care -- that is health promotion, disease prevention and early intervention -- precisely the type of health care that is most cost-effective. (National League for Nursing, 1991).
- Many diseases once thought eradicated, such as tuberculosis and measles, are now reaching epidemic proportions.

I expect that what is of most interest to you are facts which are specific to Montana.

- Over the last 10 years, the average Montana family's spending on health care rose 382% faster than wages.
- Business spending for health insurance coverage rose by more than 280%.

- o Medicaid spending has become the fastest growing sector of Montana's budget, now consuming over 15% of the general fund.
- o Despite these expenditure increases, over 100,000 Montanans are not covered by any type of health care program.

Clearly something is very wrong with the status quo.

Cost containment tends to be a distasteful aspect of any bill. It conjures up notions of governmental interference. It is certain to be opposed by those whose incomes may be affected.

Nevertheless, I believe the facts speak for themselves. Cost containment is an essential part of any health care reform bill. The HealthMontana bill offers a rationale, phased-in approach to cost containment. It provides for a five year period of adjustment to bring costs into line with the Gross Domestic Product, and allows for consideration of factors such as population increase and unanticipated provider costs. The bill specifically addresses advance budget planning to prevent precipitous closures of health care facilities or loss of health care services. The cost containment measures proposed in the HealthMontana bill, including the global budgeting provisions, have been extensively studied at the national level, and have been found to be appropriate and effective.

In summary, HealthMontana's cost containment provisions require us to live within our means while improving access to the most cost-effective forms of health care.

Each constituency involved in health care -- consumers, providers and payers -- will be required to make compromises if we are to reform and improve health care delivery in Montana, and ultimately throughout this nation. As you weigh this difficult matter, I trust in your ability to discern vested interests. Those who oppose health care reform, including cost containment, should bear the burden of justifying the outrageous costs and inadequate service in our current system.

Health care reform in Montana is both an ethical imperative and an economic necessity. The HealthMontana bill is a comprehensive, well-reasoned approach to such reform.

Thank you for allowing me the opportunity to speak, and for your work on this critically important issue.

EXHIBIT NO. 3DATE 2-10-93BILL NO. SB 285**HELENA
PEDIATRIC
CLINIC**

10 February 1993

Elizabeth P. Gundersen, M.D.
Jeffrey H. Strickler, M.D.
John A. Reynolds, M.D.

1300 N. Montana Ave.
Helena, Montana 59601
Phone 406/449-5563

To: Senate Public Health Committee

From: Jeffrey H. Strickler, M.D.
Montana Chapter, American Academy of Pediatrics

Re: SB: 285

The pediatricians of Montana, representing the children of this state and the doctors who care for them, would like to speak in favor of this bill.

Since 1986 the Academy of Pediatrics has lobbied in Washington D.C. for universal health care for all American children and pregnant women through our Access to Care Initiative. Sen. Baucus has been good enough to hear me several times on this subject. I am pleased to see that the Montana Citizen's Health Group that he sponsored has come up with a proposal that is consistent with our key principles.

These are:

- Guaranteed access: All children and pregnant women should be guaranteed financial access to health care.
- Benefit Package: Providing children and adolescents with all the services that they need with an emphasis on prevention.
- One-Tier: All children should have access to the same class of care.
- Insurance Reform: Elimination of pre-existing condition exclusion, guaranteed issue and re-issue, and community rating should be required.

SB 285 is the best effort at a state level to achieve these goals. It requires universal access to a uniform set of health benefits and stresses primary care and preventive services. It addresses our concerns on insurance reform. Although forming a One-Tier system on the state level is impossible without Federal reform, the committee's recommendation, not in this bill, for Medicaid expansion is laudatory.

Finally, I would like to be on record as saying that the pediatricians understand and are in favor of the concept of global budgeting. Certainly, the concept carries fears of change with the restriction of charges. However, the reality of creating universal access for all, and restructuring our priorities to preventive health and primary care, requires a restructuring of our expenditures and consequently a global budget. If we are really serious about providing comprehensive health care to all Montanans, including those who presently are out of the system, if we really want to improve the health of our citizens, global budgeting is not only reasonable, it is a necessity.

The pediatricians are pleased with this bill and what it promises to do for the children of Montana. We urge a do pass from this committee.

SENATE BILL 285
FEBRUARY 10, 1993

MADAM CHAIRPERSON AND MEMBERS OF THE COMMITTEE. FOR THE RECORD,
MY NAME IS GLORIA PALADICHUK, RICHLAND COUNTY COMMISSIONER, AND MEMBER
OF THE MONTANA CITIZENS HEALTH GROUP.

I WOULD LIKE TO EMPHASIZE THE IMPORTANCE OF ESTABLISHING REGIONAL
BOARDS, WHICH IS VITAL IN ORDER TO ASSURE BROAD PUBLIC PARTICIPATION.

OUR COMMITTEE FELT IT TO BE VERY IMPORTANT THAT THERE BE GRASSROOTS
INPUT INTO ALL HEALTH PLANNING IN MONTANA.

WITH MONTANA'S DIVERSITY AND GEOGRAPHIC SIZE, THE USE OF REGIONAL
PLANNING BOARDS IS ESSENTIAL.

GRASSROOTS INPUT WILL BE ASSURED AS THE REGIONAL BOARDS FUNCTION
AS ADVISORY BOARDS TO THE MONTANA HEALTH CARE AUTHORITY.

MONTANA HAS MANY UNDERSERVED AREAS NEEDING INCENTIVES TO IMPROVE
ACCESS TO HEALTH CARE. THE COMMITTEE FELT IT APPROPRIATE THAT THE
REGIONAL PLANNING BOARDS BE BASED PRIMARILY ON HEALTH CARE REFERRAL
PATTERNS. RURAL AREAS HAVE GREAT CONCERNS REGARDING ADEQUATE BASIC
PRIMARY CARE.

THESE UNDERSERVED AREAS NEED IMPROVED ACCESS TO AND USE OF
PREVENTIVE CARE, PRIMARY CARE SERVICES, INCLUDING MENTAL-HEALTH
SERVICES, AND HOME AND COMMUNITY-BASED CARE.

REGIONAL NEEDS ARE IMPORTANT AS WELL AS THE OPPORTUNITY FOR
PARTICIPATION OF TRIBAL GOVERNMENTS IN PLANNING FOR HEALTH CARE.

OUR GROUP FEELS IT IS EXTREMELY IMPORTANT THAT MONTANANS DECIDE
WHAT IS BEST SUITABLE FOR OUR CITIZENS.

I URGE YOU TO HELP MONTANA DECIDE OUR HEALTH CARE NEEDS WITH A DO
PASS RECOMMENDATION FOR SB 285. THANK YOU.

Madame Chairperson, members of the committee:

I am Kenneth Eden, a physician in private practice here in Helena Montana. I am a member of the Citizens Health Group; a past chairman of the legislative committee of the MMA; and past president of the Mt. Society of Internal Medicine.

Physicians in Montana WANT health care reform. As a Mt. physician

- I find the lack of access for > 150,000 Mt. citizens intolerable

- I acknowledge and deplore the rapidly escalating costs of medical care but recognize there is **ample blame to be shared** by physicians, attorneys, hospitals, insurers, consumers and politicians.

The bill before you, however, is not about blame. It is about a shared **desire and responsibility** we all have for finding solutions. And it provides a well designed mechanism for finding those solutions in Montana. There are aspects of the bill which have generated disagreement. Compromises have been made. In the 2 years between enactment and the Commissions report to the 1995 legislature more compromises will be necessary. **Hard choices** will be made by my profession ... and by yours. But for now the choice is easy.

Approval of Sen. Franklin's bill provides a plan for defining **basic health benefits** for all Montanans. It firmly addresses **cost containment** and at the same time and of equal importance recognizes the critical need for **limiting demand** for marginal or ineffective health care services. It specifically addresses the **waste** generated by our present **tort system**. And it begins the long overdue reform of insurance underwriting which has resulted in many Montanans being uninsurable.

With passage of this bill the Montana legislature will begin a process which should bring quality affordable health care to all Montanans.

SENATE HEALTH & WELFARE

EXHIBIT NO. 6

DATE 2-10-93

FILE NO. SB 795

COMMITTEE HEARING ON HEALTHMONTANA BILL

FEBRUARY 10, 1993

Madame Chairman Eck, members of the Committee. I am Margaret Fleming, retired Manager of the Social Security office in Kalispell, Montana. I rise in support of this bill, which is proposed to enact a universal health care act for all Montanans, Health Montana.

We have heard mention today of such issues as universal access, cost containment, data collection, global budgeting, health care boards, regional boards, and other issues addressed in this bill.

I speak today of the beneficiaries of the passage of this bill, the over 141,000 Montanans who have no health care, and the thousands more who are under-insured for health care. As an administrator of the Social Security programs, I know first-hand of the effect on a family, with no or inadequate health insurance, when an illness strikes any member of that family.

As I read, daily, of the major layoffs industry is forced to make, to stay competitive in our country today, it envisions for me a problem beyond job loss. In addition to the loss of their salaries, most of those newly unemployed people also lose their health insurance. One major illness to any of the family members can develop into financial disaster for that family. It is not just the poor who are affected by inadequate or unavailable health insurance. It could affect any one of us in this room, or in all of Montana, or to our family members. We all are a job loss away from bankruptcy due to health care costs.

This issue, to me, is not a "senior" issue. 35,000 to 45,000 of the 141,000 Montanans uninsured for health care are women of child-bearing age. Most of the other Montanans of that 141,000 are under age 65.

It was in 1937 that the Farmers Union introduced the first health care insurance plan to cover all Montana citizens. In 1944, Montana's own Senator James E. Murray and two other Senators first introduced universal health care insurance legislation.

This many years later, in 1993, the crisis is even worse. It is hoped that this committee, and then the entire legislative body, will follow the lead and vision of those courageous leaders, and will pass this Legislation. Thank you.



Montana State AFL-CIO

Donald R. Judge
Executive Secretary

110 West 13th Street, P.O. Box 1176, Helena, Montana 59624

406-442-1708

SENATE HEALTH & WELFARE

EXHIBIT NO. 7

DATE 2-10-93

BILL NO. SB 285

TESTIMONY OF DON JUDGE ON SB 285 SENATE PUBLIC HEALTH, WELFARE AND SAFETY, FEBRUARY 10, 1993

Madam Chair, Members of the Committee, for the record, my name is Don Judge. I'm here today on behalf of the Montana State AFL-CIO to lend our support to Senate Bill 285. Let me begin by saying thanks to Senator Franklin, for sponsoring this legislation, and to U. S. Senator Max Baucus who pulled together a broad coalition of providers and consumers to work on this critical issue.

America's health care system has been ill for years. Today, it's in critical condition. We're gathered here today to propose developing a cure. It's a tall order. Ten years ago, as a nation, we spent \$350 billion on health care. Last year that bill came to \$839 billion.

In 1980, the average family spent 9 percent of its total income on health care, last year, that rose to 12 percent and is expected to top 16% by the end of this decade. The feverish cost is one symptom of the disease that has infected our entire system.

And today, despite these enormous increases in health care costs, we still have more than 140,000 Montanans without health care protection, and at least that many with inadequate coverage. In fact, one in five Montanans is without health care coverage!

When any one of the nation's 37 million uninsured needs medical attention, the cost is shifted to those who do have health insurance.

Workers' paychecks have been taking a beating as their employers struggle to maintain health benefits. The average cost of health care today is more than \$3,500 per worker per year, and rose more than 15% over last year's cost. Workers are forced to pay more of the cost of those benefits even when their pay hasn't kept pace with inflation. And when workers or their families get sick, they find their once adequate "insurance" no longer covers the costs or has even been canceled!

We face a crisis in Workers' Compensation costs. This crisis is substantially driven by rising health care costs, which have gone from 30% of the system's budget ten years ago, to more than 40% today, and is projected to raise to 50% within five years!

We recognize the illness of our system. But what we need is the cure. And, just what kind of health care reform do Montana's workers want?

We want a system that provides comprehensive, quality health care for all at an affordable cost; a system that's portable to guarantee that we can take our insurance with us when we change jobs, as American workers will change jobs, on average, at least five times during their worklife.

We want **UNIVERSAL ACCESS**, a health care system that guarantees that every sick or injured American can get medical care.

We want GLOBAL BUDGETS, a system that controls duplication in purchasing and coordinates the medical resources for each community and region so we can put valuable and expensive technology to maximum use. And we want a cap on the annual increase in health care spending.

We need PROTECTION FOR RETIREES AND THOSE IN NEED, a health care system that guarantees benefits to retired workers regardless of age. And also to those who are unemployed or on strike or in school.

We want FAIR FINANCING, where the cost of health care reform is distributed as broadly and equitably as possible. Workers are opposed to taxation of employee health benefits. They are already sacrificing their income to maintain health coverage and an increased tax burden would shift the burden even more to the working families of this country.

We can resolve this crisis in our current health care system only if we make a unified commitment to finding a resolution. No matter how worthwhile they may be, no collection of piecemeal approaches, from tax credits to malpractice reform will do much to control overall costs. Only a coordinated approach can offer any reasonable hope for a functional solution.

Montanans can have universal health security - if we commit ourselves to get on with the job. To advocate anything less, is to accept the inevitability of continued chaos, in which this state's resources will continue to be misapplied and sucked into a black hole of uncontrollable cost.

There are two bills introduced in this Legislative session that could provide the medicine this struggling system needs. Combining the best elements of each will move the health care system towards recovery.

Today, we're here to recommend that the Montana Legislature give it's favorable consideration to Senate Bill 285. To some, this measure may seem radical. To us, not to do something radical would be irresponsible.

Thank you.

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624



(406) 443-5341

SENATE HEALTH & WELFARE

EXHIBIT NO. 8

DATE 2-10-93

BILL NO. SB 285

TESTIMONY OF DOUG CAMPBELL HEARD BEFORE (S) PUBLIC HEALTH, WELFARE & SAFETY FEBRUARY 10, 1993

Madam Chairperson Eck and members of the committee. My name is Doug Campbell. I am president of the Montana Senior Citizens Association and I reside in Missoula.

I would like to share with the committee some background information which led to the formation of the Montana Citizens Health Group, appointed in the spring of 1992 by Senator Max Baucus, to draw up a plan for universal health care for the citizens of Montana. The bill before you today, SB 285, is the result of the deliberations of that committee. The Montana Senior Citizens Association has been an advocate for a national universal health care plan with a single-payer system for the past several years. During that time, we have had meetings with the senator to make our views known, and many of us have written to him and talked with him personally about our strong beliefs on this subject. He always agreed that something had to be done to include all Americans in a national health plan but didn't believe that the people would support the single-payer concept. I might add here that the national polls taken over

the past few years have shown that more than two-thirds of the public support the single-payer concept.

Then, there was a sudden change in the senator's attitude on the health care issue. In late fall of 1991, Senator Baucus visited Canada to take a close look at how their health care system worked. In February of 1992, the senator spoke to a large audience at the University of Montana about his Canadian experience. He began by saying that health care should be a right for all Americans and what we needed was a national universal health care plan with a single-payer system, similar to the Canadian plan but which would take into consideration the differences between the two countries. He said he believed single-payer was the only way we would be able to afford a universal plan. He also made a statement which I considered to be very significant and that was: "Canadians have peace of mind about their health care." In other words, they do not worry about becoming ill and not being able to afford medical care. The senator went on to say that he doubted Congress would pass any meaningful health care legislation soon and proposed that Montana be a pilot state for a universal health plan. I was surprised and pleased by his proposal, and those feelings seemed to be shared by a large majority of the audience.

Senator Baucus later appointed the citizens committee which

produced SB 285. I feel fortunate to have served on the senator's committee with a group of Montana citizens who are dedicated to bringing about the changes needed to provide universal health care for all Montanans. At the initial meeting of our committee, Senator Baucus spoke briefly and ended by saying, "I will not try to tell this committee what they should do, but be BOLD."

There is a great similarity between SB 267 and SB 285 except that SB 267 would definitely establish a single-payer system while SB 285 would defer, for two years, the decision on what kind of payment system to adopt. I cannot help but feel that we have not been sufficiently mindful of Senator Baucus in his directive to be "BOLD." My concern is that, if we wait another two years to make a decision on what kind of payment system we will choose, our health care situation in Montana will continue to deteriorate and costs to escalate. I would hope the two bills could be combined in a single bill with a single-payer system, as I believe that is the only way we can eliminate the wasteful bureaucracy of the present system and effectively control costs. I thank you for the opportunity to present my testimony and urge that you give serious consideration to both of these bills.

Why we need a single-paper system.

HIT THE BIG JACK POT!

Exhibit # 8

2-10-93

SB-285

GUESS JACK BURRY'S 1992 SALARY

Jack Burry is the Chief Executive Officer of Blue Cross and Blue Shield of Ohio, a nonprofit private health insurance company.

His 1990 salary was \$622,499.90.

His 1991 salary was \$792,130.05.

The recession began in 1990, so most working Americans received only small salary increases. Jack Burry's salary rose 27%. He now earns more than three times the President of the United States.

Voter exit polls show Americans deeply want jobs and health care reform. Last year nearly 25% of Americans were unemployed for one or more weeks. Americans want health reform that unlinks health insurance from employment so they can get the care they need whether or not they are currently working. Making health care available to all would eliminate the need for companies like Blue Cross. (See reverse side for more)

HERE'S THE DEAL!

Guess Jack Burry's 1992 salary and put the amount in the box below. The winner will receive 1/100th of 1% of his salary, an amount that might approach \$100.

The contest is open until March 1, 1993. The result will be announced around April 1, 1993--April Fool's Day. If you are the winner and are working, you can save your prize to buy Christmas gifts this year. If you are the winner and unemployed, your prize will cover the premium for about one week of family health insurance.

My guess for Jack Burry's
1992 salary

\$ _____

Name _____

Address _____

Phone _____

Mail to: NEOCNHC, 1800 Euclid, Suite 318, Cleveland, Ohio 44115

MONTANA FARMERS UNION

Frank "Bud" Daniels, President

BILL NO.

2-10-93

SB 285

300 River Drive North
 P.O. Box 2447
 Great Falls, MT 59403-2447
 Phone 406 • 452-6406
 Fax 406 • 727-8216

TESTIMONY IN SUPPORT OF SENATE BILL 285

Good Afternoon. Madame Chairman and committee members, my name is Leesa Klesh and I am the Program Director for Montana Farmers Union. Montana Farmers Union is a general farm organization representing about 4,000 farm, ranch and rural families across the state. Health Care is a primary concern for all of our members. The rising costs of health care, skyrocketing insurance premiums and the lack of access to quality health care in many rural areas across our state are a few of the health care issues we are concerned about.

The rising costs of Health Care affect all Montana citizens but are compounded for farmers and ranchers, who being self employed, literally find themselves in a crippling catch - 22. Although they truly can not afford the often outrageously high health insurance premiums for their families, they must, if at all possible, purchase health insurance to protect the land that provides their livelihood.

In no other profession, are the risks of being underinsured or without insurance, so great. Because a farmer's or rancher's skills are tied to the land, he is totally displaced if he is forced to sell his assets to cover medical debts. A professional in any other field (even if all his assets are sold to cover his medical debts) in most circumstances, can use the same set of skills he had before the illness to earn a living.

Because of the monumental changes necessary to correct the current system, Montana Farmers Union actively supports comprehensive Health Care Reform for the state of Montana. We believe the two most vital components to real reform are:

universal access - quality basic health care at an affordable price for all Montanans

cost containment - through global budgeting, cooperative regional planning and efficient use of resources.

We are here today to support Senate bill 285 sponsored by Senator Eve Franklin. We have served as a member of Senator Baucus' Montana Citizens for Health Group since its creation last June and have participated in the process and development of Senate bill 285. We strongly support this bill and the reform measures it calls for. It is imperative that a new structure is created with the primary purpose being to serve and act in the best interest of ALL Montanans as a new Health Care plan is developed for our great state.

Montana Farmers Union supports the development of a single payer system for Montana. We urge you to pass legislation this session to begin the process of reform.

THE TIME IS NOW FOR BOLD ACTION AND RESPONSIBLE LEADERSHIP.

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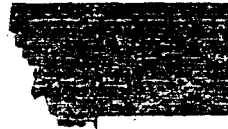
MONTANA CONSORTIUM
*for Excellence in
Health Care*

SENATE HEALTH & WELFARE

EXHIBIT NO. 10

DATE 2-10-93

BILL NO. SB 285



My name is Donna Schramm and I am speaking in favor of Senate Bill 285. I am a member of the committee that prepared this bill. I am a Registered Nurse, parent of a child with a developmental disability, daughter of aging parents and like all of you, a consumer of health care.

I speak to you as member of the health care system. I am presently the Administrator of the Montana Consortium for Excellence in Health Care. The Consortium is a group of seven Montana Hospitals and a part of a national initiative sponsored by the Robert Wood Johnson Foundation and the Pew Charitable Trusts. The project, Strengthening Hospital Nursing: A Program to Improve Patient Care, is an effort to bring about a fundamental change in the US Hospital - that is, from a discipline-driven, departmentalized institution to a patient-driven, unified one.

The process used by the committee to develop the bill now before you exemplifies the characteristics being promoted by the Strengthening Hospital Program - that is Interactive Planning. The emphasis is on what is best for the patient and how can the health care delivery system be created to meet patient needs. The committee's process has been based on a participative model, study of the current situation with input from a wide variety of sources and

P.O. Box 35200
Billings, Montana
59107-5200

with a vision of what our health care system can be in serving all Montanans.

I speak to you as the parent of a child with a developmental disability. A child who will need the continuing assistance of others to develop and live out her potential as a contributing member of our society. In many ways her circumstances are not so different than the rest of us - she needs health care that is accessible and affordable. She will however, never be fully independent or able to cope with the current tangled complex health care system we now have. She and others in her situation, must have basic services in a way that promotes their maximum level of independence and human dignity.

I speak to you as the child of aging parents. People who are now in the position of needing assistance with ever increasing health care costs. People who have been independent, self-sufficient, contributing citizens. The complexities they face in knowing how to access the system, understand it once they are in it and then coping with the paperwork jungle is incredible. Those of us inside the system have little idea the maze our patients face - until we or someone we care about needs continuing health care - as in my case a child and parents.

I speak to you as a consumer of health care - and as a health care professional, one who is supposed to understand all the intricacies and know how to get myself around it. Even with all that - it is not easy! It can be simpler, it can be more efficient - but fundamental changes have to take place. Services must be set up to meet the needs of patients - not the providers of that service as is now all too often the case.

This bill provides the mechanisms for such fundamental change to occur. It won't be easy, it probably won't please anyone 100% - if we do it right, what we develop won't look anything like we have now. That may be a frightening prospect, if some of us feel comfortable with what we have now, and if others of us think we will be taken care of if it becomes needed. Both of those scenarios - being comfortable and a sense of security may be just our own delusions. For many Montanans adequate health care simply is not a reality. For that reality to be changed will require capable, and interested people to get involved - that means all of us - not just the health care professionals, not the insurance companies and not just the various professional organizations. It means that each of us holds a piece of the puzzle, it means that no one person or organization holds the "right solution". It means as the various councils and programs are developed through this legislation, we have to listen and learn from each other - we have to be willing to ask each other what may seem to be simple questions - Why does it have to be this way? And What if we tried it another way? All of us can be involved and can contribute to the process of creating our future health care delivery system.

Parents, children, professionals, consumers all - we have a great opportunity before us. I urge your support of this bill. Thank you.

SENATE PUBLIC HEALTH COMMITTEE

SENATE BILL 285 TESTIMONY

2/10/93

Madame Chairwoman, members of the committee, my name is Michael Regnier. Today I would like to speak in favor of Senator Franklin's health care reform bill on behalf of Montana People's Action. MPA is a statewide membership organization with over 7,500 low and moderate income family members and donors. Several leaders and members of MPA testified earlier this week in favor of Senator Chris Christiaens' health care reform bills, Senate Bills 262 and 290. Today I am here to express MPA's support of Senator Franklin's bill today.

Many people feel that American citizens and the news media are too hasty in using the term "crisis" in describing events and circumstances that affect the populace. However, "crisis" is truly the most accurate term to describe the everyday experience of millions of Americans and hundreds of thousands of Montanans as they try to obtain the health care they need in order to live healthy and productive lives. We play by the rules every day, and yet 141,000 Montana citizens are unable to obtain basic health insurance coverage. We feel that Senate Bill 285 is a realistic and achievable means of solving this crisis. However, we also feel that several components of the bill could be strengthened in order to provide the maximum amount of protection for our citizens, both in terms of their ability to pursue gainful employment as well as having some reasonable peace of mind that they may, at any time, be confronted with a major illness or disability without the near certainty of being bankrupted in the process.

First, we feel that the bill, as it is currently written, ~~and~~ provides inadequate protection for individuals, or "non-group" customers. Because of the large number of employers in Montana who are so small as to not be able to constitute a group of even three members, it makes no sense to only protect people whose employers only have between 3 and 25 employees. This is also a significant barrier to obtaining coverage for people who are self-employed, and discourages the initiation of small businesses in which Montana takes such pride, and rightly so.

Second, the provisions referring to continuity should contain specific mention of the types of policies people may be leaving as the result of a new job or other change in circumstances. As written, there is some question as to whether the continuity of coverage provisions would apply to an individual who is leaving various kinds of coverage, such as Medicare, Medicaid, Medical Assistance, Champus, HMO contracts, or other such policies. Without these provisions, we will continue to see many such people be reluctant to even attempt going to work for fear of losing their coverage under these programs, though they may very much want to do so. We cannot allow people to remain

UN

unnecessarily trapped in public programs that consume such a huge portion of the State and Federal budget by overlooking this provision. Failure to do so would undoubtedly cost Montana taxpayers millions of dollars annually who could actually be adding millions of dollars to the tax base.

Third, it is time to put an end to the standard insurance industry practice of "cherry picking" in Montana. We respectfully urge Senator Franklin and the Committee to implement community rating in its purest form, without the use of "rate bands." Experience in other states that have implemented health insurance reform and left rate bands intact has shown that this practice has actually increased the cost of insurance underwriting as companies attempt to squeeze individuals into these compressed zones of increased premium rates. Apart from the fact that this substantially defeats the purpose of community rating, this practice also has the same result on administrative cost savings.

Finally, we urge the Committee to enact these reforms quickly, as the urgency for reform is increasing dramatically with each year that passes with these issues left unresolved. It is time to address the discrimination and profiteering forced upon our citizens by the medical-industrial complex. If health insurance companies wish to compete in the marketplace in Montana, then let them compete while providing a product that we can both obtain and afford.

We applaud the efforts of Senator Franklin, Senator Baucus, this Committee, and all those who participated in the development of this bill. We urge you to pass it with the changes I have just described, and look forward to working with all those who will be involved in finalizing this bill and implementing its provisions. Thank you for your time.

CJ



**BlueCrossBlueShield
of Montana**

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

TESTIMONY ON SB 285

Before Senate Public Health Committee

February 10, 1993

SENATE HEALTH & WELFARE

EXHIBIT NO. 12

DATE 2-10-93

BILL NO. SB 285

Chairman Eck and Members of the Committee. My name is Chuck Butler. I'm a Vice President of Blue Cross and Blue Shield of Montana.

I'm here today -- as I was last Friday -- to endorse the need for major-comprehensive-change in the way we provide and finance health care in Montana.

As has been said so often, health care costs are rapidly rising and the public's ability to pay is getting more difficult every day.

According to a document you received last Friday, Montana spent \$1.6 billion in health care in 1990. \$651.6 million, or 40%, went to hospitals. \$320 million, or 19.5%, went to doctors. \$138 million was spent on drugs, \$135 million on nursing homes, and \$85.3 million on dental care.

I mention those numbers to compare them with the amount Blue Cross and Blue Shield of Montana paid out in 1991 for hospital and doctor services. We paid hospitals approximately \$71 million and doctors and other providers almost \$50 million.

I will now address specific sections in SB 285 and offer a few recommendations:

1. Under definitions, in Section 2, Pages 5 and 6, there needs to be included definitions of global budgeting and expenditure targets that are referenced on pages 8 and 9 in Section 5 dealing with cost containment. I suspect we could ask each person here to give us a definition of these two measures and get a variety of ideas.

Also on page 5, the definition of health service corporations should be added to health insurer.

In Section 5, on page 8, we would propose on line 15 to change the word "shall" to "may." Also on page 8, beginning on line 24, we have a few issues that we believe need to be addressed.

First, this subsection states that all payors, including Medicaid, Medicare, Workers' Compensation, Veterans' Administration, Indian Health Service, Department of Defense, the

Federal Employee Program, Blue Cross Blue Shield, commercial insurers and third party administrators that pay claims for self-insured groups, must pay the same rate for like services. If the intent is to reduce the level of reimbursement that private insurers pay on behalf of our customers to the level now paid by government programs that could be a good deal; however, if the intent is to raise government payments, I doubt that will happen with our current fiscal situation here and in Washington.

And, without any number of waivers from Congress and the Clinton Administration, this is not doable. Further, an all-payer system eliminates the ability of group purchasers of services as proposed in Senator Yellowtail's bill to negotiate reimbursement rates for the people they represent.

Second, this same subsection in essence says all health care providers will be paid the same when providing a similar service. Year after year in debates over mandated benefits you've been told by allied providers that they provide care at a fee lower than M.D.s. If the intent of this section is to reduce the reimbursement for professional services, that's one thing, but if it means all professional providers' level of reimbursement will be raised to the level of M.D.s that's not cost containment.

While sounding like a good idea, the establishment of an all-payer system would also continue to encourage the delivery of care in a disjointed system, making it difficult for coordinated, managed care systems such as health maintenance organizations and preferred provider arrangements to use innovative reimbursement programs to achieve cost containment goals.

In terms of payment policies you could say, "one size does not fit all."

As I said in my testimony on SB 267, the Health Authority's tasks should be clearly spelled out in any health reform law but the Authority should have the flexibility to determine, after careful study, what is best for Montana, after knowing what Congress and the new President propose.

If we require the Authority to include all the items listed in Subsection 3 on page 8 under cost containment we have tied the Authority's hands and predetermined its decisions before it has all the information it can gain from the data it acquires, the public hearings it holds, and the actions of our federal government.

On line 16, on page 14 of Section 10 dealing with the appointment of members to the regional planning boards, we would propose that these folks be selected within 90 rather than 180 days of the appointment of the State Authority. These regional bodies are being asked to do many things. One major task, as outlined on page 15, in Section 15, is for each board to submit a regional health care resource management plan to the State Authority to assist in the development of a state health plan. A date should be included with this task, so it's clear that the regional boards' input must be included in the State Authority's plans.

In Section 12, dealing with data, we would propose that you consider much of what is

Exhibit II 12
2-10-93
SB-285

included in SB 267. As I said the other day, data on costs, charges, utilization, resources and the availability of services, to name a few, will be critical to the Authority as it makes decisions on how to structure a single payer and multi-payer system and in the development of a state health care resource management plan.

With regard to Section 13, we are in agreement with Senator Franklin and the Auditor's office on the substitution of the existing language with the Commissioner's Amendments which follow the NAIC and are tailored to Montana's needs. This in itself is a major change in the way insurers will do business in Montana and we welcome and support these reforms.

Chairman Eck, Blue Cross and Blue Shield of Montana has been an active participant with the Montana Hospital Association, the Montana Medical Association, purchasers of health care, our Congressional delegation, the administration of former Governors Stephens and Schwinden, and now, the Racicot administration, on health care reform matters.

We support and encourage passage of comprehensive changes in our state's health care system and want to work with you, Senators Franklin and Yellowtail and all those who want to ensure that all Montanans have access to high quality and affordable health services. In so doing we hope you and your committee will use SB 285 as a starting point and adopt the best features of the health care reform bills before you.

Thank you.

Report to the Governor

Montana Task Force

BIOMEDICAL INFORMATION

Montana Task Force

The original is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

MONTANA

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February 10, 1993
Wednesday

MONTANA MEDICAL ASSOCIATION SUGGESTED AMENDMENTS TO SB 285

1. Page 7, line 22.
Following: "available"
Insert: "a system of necessary and effective health care benefits."
Strike: "a uniform system of health care benefits."
2. Page 7, line 25.
Following: {Sections 5 through 8}.
Add: "Nothing in this bill shall constrain Montana residents from seeking health care services not specifically delineated in the health care benefits package."
3. Page 8, line 15.
Following: "shall"
Insert: "most strongly consider"
Strike: "include" on the same line
4. Page 9, line 1.
Following: "items"
Insert: "addressing the cost shifting caused by the current inadequacy of the Medicaid, Medicare, and other governmental pay systems"
5. Page 9, line 3.
Following "provided"
Insert: "utilizing a resource based relative value system"

See reverse, excerpt from Federal Register sample of relative value units.

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ADDENDUM B

RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	GLOBAL FEE PERIOD	SURGICAL/ NON-SURGICAL UPDATE
31201	A		REMOVAL OF ETHMOID SINUS	8.11	7.18	0.77	16.06	090	S
31205	A		REMOVAL OF ETHMOID SINUS	9.89	8.23	0.83	18.95	090	S
31225	A		REMOVAL OF UPPER JAW	15.56	19.98	2.43	37.97	090	S
31230	A		REMOVAL OF UPPER JAW	21.57	22.27	2.54	46.38	090	S
31250	A		NASAL ENDOSCOPY, DIAGNOSTIC	1.12	1.41	0.15	2.68	000	S
31252	A		NASAL ENDOSCOPY, POLYPECTOMY	3.05	3.45	0.37	6.87	000	S
31254	A		REVISION OF ETHMOID SINUS	4.63	6.57	0.71	11.91	000	S
31255	A		REMOVAL OF ETHMOID SINUS	7.13	10.83	1.17	19.13	000	S
31256	A		EXPLORATION MAXILLARY SINUS	3.37	3.86	0.42	7.65	000	S
31258	A		NASAL ENDOSCOPY, SURGICAL	2.36	2.72	0.29	5.37	000	S
31260	A		ENDOSCOPY, MAXILLARY SINUS	2.23	2.87	0.32	5.42	000	S
31263	A		ENDOSCOPY, MAXILLARY SINUS	4.25	3.68	0.44	8.37	000	S
31265	A		ENDOSCOPY, MAXILLARY SINUS	3.06	6.46	0.71	10.23	000	S
31267	A		ENDOSCOPY, MAXILLARY SINUS	3.15	7.57	0.83	11.55	000	S
31268	A		ENDOSCOPY, MAXILLARY SINUS	3.27	2.78	0.26	6.31	000	S
31270	A		ENDOSCOPY, SPHENOID SINUS	2.71	0.98	0.10	3.79	000	S
31275	A		SPHENOID ENDOSCOPY, SURGICAL	3.79	6.21	0.67	10.67	000	S
31277	A		SPHENOID ENDOSCOPY, SURGICAL	4.22	7.31	0.80	12.33	000	S
31285	A		ENDOSCOPY, COMBINED SINUSES	3.87	3.23	0.17	7.27	000	S
31299	C		SINUS SURGERY PROCEDURE	0.00	0.00	0.00	0.00	YYY	S
31300	A		REMOVAL OF LARYNX LESION	13.61	11.86	1.31	26.78	090	S
31320	A		DIAGNOSTIC INCISION LARYNX	4.65	3.96	0.50	9.11	090	S
31360	A		REMOVAL OF LARYNX	15.56	19.84	2.24	37.64	090	S
31365	A		REMOVAL OF LARYNX	22.36	27.80	3.17	53.33	090	S
31367	A		PARTIAL REMOVAL OF LARYNX	19.44	17.64	1.92	39.00	090	S
31368	A		PARTIAL REMOVAL OF LARYNX	24.30	27.42	3.13	54.85	090	S
31370	A		PARTIAL REMOVAL OF LARYNX	18.96	17.60	1.92	38.48	090	S
31375	A		PARTIAL REMOVAL OF LARYNX	18.96	15.20	1.60	35.76	090	S
31380	A		PARTIAL REMOVAL OF LARYNX	18.96	17.69	1.92	38.57	090	S
31382	A		PARTIAL REMOVAL OF LARYNX	18.96	16.45	1.82	37.23	090	S
31390	A		REMOVAL OF LARYNX & PHARYNX	21.67	35.70	4.15	61.52	090	S
31395	A		RECONSTRUCT LARYNX & PHARYNX	26.83	38.44	4.53	69.80	090	S
31400	A		REVISION OF LARYNX	9.28	8.00	0.93	18.21	090	S
31420	A		REMOVAL OF EPIGLOTTIS	9.28	8.28	0.86	18.42	090	S
31500	A		INSERT OF EMERGENCY AIRWAY	2.39	1.17	0.14	3.70	000	M
31502	A		CHANGE OF WINDPIPE AIRWAY	0.67	0.60	0.07	1.34	000	S
31505	A		DIAGNOSTIC LARYNGOSCOPY	0.63	0.44	0.05	1.12	000	S
31510	A		LARYNGOSCOPY WITH BIOPSY	1.97	0.57	0.07	2.61	000	S
31511	A		REMOVE FOREIGN BODY, LARYNX	2.21	0.98	0.10	3.29	000	S
31512	A		REMOVAL OF LARYNX LESION	2.12	1.83	0.20	4.15	000	S
31513	A		INJECTION INTO VOCAL CORD	2.15	3.54	0.38	6.07	000	S
31515	A		LARYNGOSCOPY FOR ASPIRATION	1.84	1.16	0.14	3.14	000	S
31520	A		DIAGNOSTIC LARYNGOSCOPY	2.62	1.68	0.18	4.48	000	S
31525	A		DIAGNOSTIC LARYNGOSCOPY	2.69	2.25	0.23	5.17	000	S
31526	A		DIAGNOSTIC LARYNGOSCOPY	2.63	3.57	0.38	6.58	000	S
31527	A		LARYNGOSCOPY FOR TREATMENT	3.35	3.06	0.30	6.71	000	S
31528	A		LARYNGOSCOPY AND DILATATION	2.43	2.73	0.30	5.46	000	S
31529	A		LARYNGOSCOPY AND DILATATION	2.75	2.52	0.25	5.52	000	S
31530	A		OPERATIVE LARYNGOSCOPY	3.48	3.72	0.40	7.60	000	S
31531	A		OPERATIVE LARYNGOSCOPY	3.82	5.75	0.62	10.19	000	S
31535	A		OPERATIVE LARYNGOSCOPY	3.24	4.10	0.46	7.80	000	S
31536	A		OPERATIVE LARYNGOSCOPY	3.25	5.71	0.61	9.57	000	S
31540	A		OPERATIVE LARYNGOSCOPY	4.23	5.73	0.63	10.59	000	S
31541	A		OPERATIVE LARYNGOSCOPY	3.65	7.11	0.77	11.53	000	S
31560	A		OPERATIVE LARYNGOSCOPY	5.59	5.12	0.53	11.24	000	S
31561	A		OPERATIVE LARYNGOSCOPY	5.02	10.31	1.10	16.43	000	S
31570	A		LARYNGOSCOPY WITH INJECTION	3.96	5.89	0.62	10.47	000	S
31571	A		LARYNGOSCOPY WITH INJECTION	3.61	6.59	0.71	10.91	000	S
31575	A		DIAGNOSTIC LARYNGOSCOPY	1.12	1.60	0.17	2.89	000	S
31576	A		LARYNGOSCOPY WITH BIOPSY	2.02	3.09	0.33	5.44	000	S
31577	A		REMOVE FOREIGN BODY, LARYNX	2.53	3.76	0.37	6.66	000	S
31578	A		REMOVAL OF LARYNX LESION	2.91	4.73	0.50	8.14	000	S
31579	A		DIAGNOSTIC LARYNGOSCOPY	2.32	2.39	0.26	4.97	000	S
31580	A		REVISION OF LARYNX	11.28	15.86	1.67	28.81	090	S
31582	C		REVISION OF LARYNX	0.00	0.00	0.00	0.00	090	S
31584	A		REPAIR OF LARYNX FRACTURE	18.96	13.03	1.37	33.36	090	S

* All numeric CPT HCPCS Copyright 1992 American Medical Association

SENATE HEALTH & WELFARE

EXHIBIT NO. 15

DATE 2-10-93

BILL NO. SB 285

Testimony on SB #285; "An act providing for universal health care access, health care planning, and cost control"

Position: Support

By: Wallace J. Henkelman, RN,MSN, Montana Nurses Association

The Montana Nurses Association is the professional organization and the voice of registered nurses in Montana. Among its goals is the promotion of access to quality health care for all the people of Montana.

At present access to such care is severely limited by inequities in our health care systems. This is evident in the facts that over 140,000 Montanans have no health insurance coverage of any kind and that, in addition, there are persons in our rural areas who regardless of insurance status have little or no access to health care providers.

SB285 addresses the former problem through the establishment of universal access coverage, insurance reform, and cost containment provisions. It addresses the latter by proposing assistance with education for persons in rural areas who desire to become health care providers and by establishing tax incentives for providers who practice in underserved areas.

As well as the content of the proposed changes in the health care system we need to look closely at the methods being used to make those changes. There are two principles of change to be utilized in the implementation of SB285 that I would like to point out.

The first is that a lasting and meaningful change will occur only if all parties involved in the process being changed are participants in the planning of the change. A change in health care provision would thus require input from consumers, providers, and financing agencies. SB285 provides for such collaboration rather than imposing the desires of one sector upon the others.

The second principle is that major changes are not made without careful consideration, gathering of relevant information, and extensive planning. SB285 facilitates those activities by allowing a number of options, the most important being postponing the decision to use a single payor or multiple payors as the financing mechanism until a time when consideration has taken place.

For both the content of the proposed changes and the proposed methods of change the Montana Nurses Association supports SB285.

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SENATE BILL 285 -- HEALTH CARE REFORM
Position of the Montana Association of Life Underwriters
February 8, 1992

SENATE HEALTH & WELFARE

EXHIBIT NO. 16

DATE 2-10-93

BILL NO. SB 285

Senate Bill 285, introduced by Sen Franklin (D - Gt Falls), proposes "comprehensive" health care reform. The bill creates a five person Health Care Authority (Authority) appointed by the Governor. The Authority and its staff would become the focal point of a number of reform measures. SB285 requires the Authority to develop and submit to the next legislature:

- two statewide universal health access plans, one based on a single payor concept and the other based on a "regulated multiple payor" concept;
- a cost containment plan with the goal of reducing the average annual increase in health care costs to the overall inflation rate by 1999;
- a health resources management plan to guide distribution of health care expenditures;
- a billing simplification and paperwork reduction plan to cut administrative costs;
- studies of medical malpractice tort reform measures and exemptions from anti-trust laws; and
- a study of long-term care needs and recommendations.

In order to get public input to all the above, the bill creates five health planning regions and establishes planning boards for each. The Authority would complete all the plans and recommendations, except long term care, by October 1994.

In addition, the SB285 directs the the Authority to develop and maintain a unified health care data base including an inventory of existing resources, a needs assessment, and evaluations of the cost and efficacy of protocols and providers. The bill replaces the existing statutes on health insurance with "guidelines" for the Commissioner to enforce by rule.

MALU POSITION: The Montana Association of Life Underwriters (MALU) supports the goal of assuring universal access to affordable health insurance coverage. We believe SB285 provides a good starting point for developing the reforms needed to reach this goal.

However, to assure affordable access to health coverage for all Montanans, MALU supports making several significant changes in SB285.

1. In light of the fact that roughly 85% of all Montanans currently receive health insurance through our current partnership between private insurance and public sector programs, MALU believes expanding the existing voluntary private-public partnership provides the

most cost effective way of achieving the goal of universal access. Section 4 of SB285 requires the Authority to develop two statewide plans, one based on on a single payor concept and the other on a regulated multiple payor concept. Yet the bill fails to define either term. We believe the Legislature must amend SB285 to specifically identify what the proponents intend to include in the scope of the regulated multiple payor plan and, if the concept does not include expanding the existing private-public partnership, to include a statewide plan based on targeted reforms of the current system as a third proposal the Authority must submit to the next Legislature. In addition, we believe each statewide plan developed by the Authority must contain an actuarially sound estimate of the cost of implementation. MALU support for SB285 depends on these changes.

2. SB285 recognizes the central role of effective cost containment measures in the solutions to the problem of universal access, and for that MALU commends the sponsor. However, we question whether every plan should contain all the measures listed in Section 5. For example, we question the appropriateness of global budgeting in a regulated multiple payor system or in expansion of the existing private-public partnership. MALU suggests amending Section 5 to require the Authority to consider all the cost containment measures listed, but to only include those it deems appropriate to the specific plan. Moreover, we suggest adding two additional cost containment measures to the list the Authority should consider:

- a system for the reduction in the use of defensive medicine by adopting practice protocols, which would give providers guidelines to follow for specific procedures and impose limits on liability if the provider follows the guidelines in a manner not grossly negligent; and
- a cost-benefit analysis of all existing state mandated health insurance benefits as defined in HB75 and a recommendation to 1995 Legislature to eliminate those not found cost effective.

The Authority should have the ability to consider any other cost containment measure it deems potentially effective.

3. Although the Authority should study administrative simplification and electronic billing as provided in Section 7, we believe the Commissioner of Insurance should have the ability to adopt a uniform claim form and a standardized explanation of benefits in the interim by administrative rule.

4. The Legislature should expand the unified health care data base required in Section 12 to include a comparison of costs of commonly performed procedures within a location and require that the Authority make these comparisons available to the public.
5. The insurance "reforms" proposed in Section 13 will cause massive disruption in the current market for private health insurance, resulting in a greater number of uninsured and substantially higher premiums for many Montanans. As a result, MALU will stridently oppose SB285 unless the Legislature deletes or significantly alters this section.

Current studies show that a large portion of the uninsured have some tie to the job market. Nationally, nearly two-thirds of the uninsured worked on a full- or part-time basis; 35% worked full-time or lived in a family with a full-time worker, yet failed to obtain employment based health insurance. Almost all the uninsured with ties to the job market work for small businesses. As a result, the most effective way to address the problem of the uninsured is to improve access to and affordability of insurance in the small employer market.

MALU supports radically revising the laws governing availability of small employer group health insurance. If the Legislature adopts the principal elements of MALU's proposal:

- Small employers would be guaranteed the right to obtain an essential level of coverage for all their employees regardless of the group's health history.
- Renewability of coverage would be guaranteed except for nonpayment of premiums or fraud or misrepresentation.
- Premium rate variations would be limited among similar groups and rate caps would be placed on premium increases.
- Coverage would be portable — employees would not lose coverage when moving from job to job or when their employer changed carriers.

6. The Commissioner of Insurance should serve on the Authority as an ex officio member.

MALU believes since society as a whole must choose between health care and other uses of money, as often as possible these decisions should be made by informed individual consumers. Although society as a whole should provide health care for the less fortunate, most people should pay the real cost of what they get. On the whole, we believe good individual incentives and decisions will lead to good social outcomes.

Amendments to Senate Bill 285, Introduced Copy
Proposed by the Montana Association of Life Underwriters
February 10, 1993

1. Page 7, line 19.
Following: "concept"
Insert: ", a recommendation for a statewide universal access plan based on targeted reforms to the existing voluntary private - public partnership"
 2. Page 7, at the end of line 25.
Insert: "Each statewide plan must contain an actuarially sound estimate of the costs of implementing the plan through the year 2005."
 3. Page 8, line 15.
Following: "shall"
Strike: "include"
Insert: "consider"
 4. Page 8, line 20.
Following: "care"
Insert: ", including expanded utilization review and managed care methods"
 5. Page 9, following line 4.
Insert: "(d) a system for reducing the use of defensive medicine by adopting practice protocols which would give providers guidelines to follow for specific procedures and impose limits on liability if the provider follows the guidelines in a manner not grossly negligent;
(e) a cost benefit analysis of mandated benefits and a recommendation to the next legislature to eliminate those it finds are not cost effective. For the purpose of this subsection, "mandated benefit" means state legislation that prescribes the content of disability insurance purchased from a health insurer. The term includes but is not limited to extended coverages for certain categories of individuals, covered benefits including mandated options and benefits limited to certain types of contracts, and coverages for freedom of choice practitioners;"
- Renumber: subsequent subsections and correct internal references.
6. Page 9, line 14.
Following: "providers,"
Insert: "health insurers"
 7. Page 11, line 4.
Following: "billing;"
Insert: "and"

SENATE HEALTH & WELFARE

EXHIBIT NO. 17

DATE 2-10-93

BILL NO. SB 285

8. Page 11, line 8.
Following: "payers"
Strike: "; and"
Insert: ";"
9. Page 11, following line 8.
Strike: subsection (c).
Insert: "(2) The commissioner of insurance may, after consulting with the authority, adopt administrative rules requiring health insurers to use uniform claims forms and standardized explanation of benefits."
Renumber: subsequent subsections.
10. Page 12, line 25.
Following: "providers"
Strike: "or"
Insert: ", payors including health insurers and"
Following: "consumers"
Strike: "or both"
11. Page 16, line 14.
Following: "protocols;"
Strike: "and"
Insert: "(d) compare costs of commonly performed health care procedures among providers and health care facilities within a region and make the data readily available to the public; and"
Renumber: subsequent subsections.
12. Page 18, following line 3.
Strike: section 13 in its entirety.
Renumber: subsequent sections and amend effective date to conform.



SENATE HEALTH & WELFARE
EXHIBIT NO. 18
DATE 2-10-93
BILL NO. SB 285

Senator Eck and Members of Members Committee:

For the Record, I am Greg Eklund, Acting Executive Director of the Montana Democratic Party and I stand before you today in support of Senate Bill 285.

Montana, like the rest of our nation, faces a serious crises in the area of health care. While the deliberations of this session will be largely and appropriately aimed at solving the fiscal crises of our state, I think it's just as important to focus attention on the crises of providing affordable health care.

The platform of the Montana Democratic Party speaks very clear on this issue. Our party believes that comprehensive health care is a right for all Montanans, and not only those who have the financial ability to afford health insurance. A good health care system should allow for access, support preventive services, provide for portability of health care coverage and include cost containment measures.

Clearly, the most important goal of any health care plan is the coverage of all Montanans. With over 140,000 of fellow Montanans who have no health care coverage, the time is now to make a positive step toward a system that is compassionate and provides universal coverage for everyone.

Thank you for your time. Again, the Montana Democratic Party recommends a do pass on Senate Bill 285.

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SENATE HEALTH & WELFARE

EXHIBIT NO. 19

DATE 2-10-93

BILL NO. SB 285

AARP Testimony

Health Care Bill SB 285

Senate Hearing Feb. 10, 1993

Madam Chairman & MEMBERS OF THE Committee

For the record, my name is Bill Olson and I am a member of the State Legislative Committee of AARP(American Association Of Retired Persons). AARP has approx. 110,000 members in the State of Montana__ one for every eight persons in the state. AARP members are 50 years of age or older.

On behalf of the AARP State Legislative Committee, I appear in support of SB 285. This piece of legislation is extremely important to the citizens of Montana as it is the initial step in much needed Health Care Reform.

On a national level, AARP has developed a plan known as Health Care America. Providing health care for all is the primary goal of the plan, as it should be for any health reform plan. AARP's Health Care America calls for a multi-payor plan as opposed to a single payor plan. SB 285 provides for the authority to recommend plans for both types, as outlined in Section 4, lines 14_25 on page 7.

We testified in favor of the concept proposed in SB 267 by Senator Yellowtail and we are testifying in favor of SB 285 as proposed by Senator Franklin.

The bottom line is that Health Care reform legislation, whether it be SB 267 or SB 285 or a blending of the two bills, Health Care Reform is urgently needed and AARP urges your committee's favorable consideration.

Thank you.



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Montana AARP State Legislative Committee
1992-1993 Position Paper

STATE HEALTH CARE REFORM

POSITION: The goal is to reform state health care and long term care incorporating AARP's Health Care America approach of providing health care for all. Until the state system achieves such reforms, the Montana State Legislative Committee will support incremental legislative steps to achieve this reform.

PROBLEM: Too many people in Montana have no health insurance or at best are under-insured. This applies to young, elderly, retired and employed people as well. ("Reforming the Health Care System: State Profiles" -- Pages 79-81.)

Due to "cost-shifting" in an effort to pay for the uninsured, health care insurance costs are becoming prohibitive.

Billing and related paper work detract from the services of professionals and the hospitals. Additional personnel are required for clerical and administrative work. Duplication of paper work is also an on-going problem.

SOLUTION: State health care reform requires:

1. Incentives to employers, particularly small business, to provide health care insurance for their employees.
2. Coverage for all Montanans to abolish the need for "cost-shifting."
3. Consolidated billing allowing professionals to treat patients and not be bogged down with undue paperwork.
4. Establish a continuum of services emphasizing in-home care through custodial long term care.

CONTACT: Bob Souhrada, State Legislative Committee Member
915 13th Street West, Columbia Falls, MT 59912
(406) 892-4642

Montanans for Universal Health Care

"... to ensure affordable, accessible health care for all Montanans..."

TESTIMONY OF CHRISTIAN MACKAY BEFORE THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE ON SENATE BILL 285

Madam chair, members of the committee, for the record my name is Christian Mackay. I'm here today on behalf on Montanans for Universal Health Care. We rise in support of Senate Bill 285.

We salute Sen. Franklin and the members of the Montana Citizens Health Group. Their effort, hard work and compromise have put forth this bill with a purpose that is vital to all citizens of this state and paramount to MUHC. That is reforming our current health care system to extend health services to all Montanans.

As you know, MUHC is the impetus behind Sen. Yellowtail's bill SB 267. However, both bills share the goal of comprehensive reform of our current system. Bearing that in mind, I would like to voice some concerns on behalf of Montanans for Universal Health Care.

SB 285 begins with a statement of intent, which is normal for a bill of this magnitude. But what is notably absent is a statement of health care policy for the state of Montana. We feel that policy must be clearly articulated. This will keep the reform effort consistent with the intent of its makers.

The Montana health care authority established by SB 285 has five voting and two non-voting ex-officio members. An authority is integral to state-wide reform. However, we are concerned with the ex-officio members of this authority, the directors of the Dept. of Social and Rehabilitation Services and the Dept. of Health and Environmental Sciences. While their input and expertise will be beneficial, we feel that making them board members is unnecessary.

SENATE HEALTH & WELFARE

EXHIBIT NO. 20

DATE 2-10-93

BILL NO. SB 285

We suggest a mechanism whereby the authority can deal with conflict of interest of its members. We wish to raise the concern of authority members participating in proceedings in which that member has a personal or financial interest. We also suggest that the authority be given quasi-judicial power. We feel that a quasi-judicial body will be better able to deal with unforeseen situations during the reform process.

Last, we would include a specific role for the authority beyond its initial four year term. We feel that it is important to specify whether the authority will oversee the reform plan chosen by the legislature in 1995, or if a new authority will be tailored to fit the plan. It can be difficult to retro-fit a governmental body after it is formed.

It is important to note that the concerns that we raise are technical in nature. We do support the objectives and goals set forth in this bill. We would like to suggest the appointment of a sub-committee to hammer out these differences. Thank you.



MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

SENATE HEALTH & WELFARE

EXHIBIT NO. 21

DATE 2-10-93

BILL NO. SB 285

Testimony before the
Senate Public Health, Welfare & Safety Committee
by James F. Ahrens, President
Montana Hospital Association
February 10, 1993

The Montana Hospital Association represents 53 community-based acute care hospitals.

Like all Montanans, hospitals are deeply concerned about the condition of our state's health care system. Every day, hospitals see the evidence that the current system is afflicted by serious problems.

The Montana Hospital Association is strongly committed to comprehensive health care reform. For two years, we have been actively involved in developing a plan to restructure our state's health care system.

Montana's hospitals strongly support SB 285. We believe SB 285 is the most appropriate and workable approach to achieving comprehensive health care reform.

We have arrived at this position after an extensive examination of the problem and the possible solutions.

Montana's hospitals are community-based, governed by a local board of trustees. Their mission is to provide the people of their community with high quality health care services at a reasonable and fair price.

The present health care system makes that virtually impossible. The present health care system -- with its crazy quilt of reimbursement schemes and misdirected incentives -- is driving many small community hospitals to the brink of closure.

For example, the average net patient margin in 1991 was 0.2 percent statewide. For the 29 hospitals with fewer than 30 beds, the net patient margin was -18.5 percent.

Unless this system is reformed, access to health care services will become increasingly restricted as communities decide they can no longer afford to keep their hospitals open.

Reform is also needed to end the cost-shifting that currently plagues hospitals, physicians and consumers alike.

Because the Medicare, Medicaid, workers compensation programs don't pay the full cost of treating their beneficiaries, hospitals are forced to charge privately-insured persons higher rates.

That raises health insurance premiums for Montana's workers, small businesses, farmers and ranchers.

The health care system is like a balloon. If you try to reduce its size by squeezing it, the balloon just pops out somewhere else. The only way to end cost-shifting is to restructure the entire system.

Adding to the financial problems facing hospitals is the rising cost of charity care provided by hospitals.

In one sense, we have no access problem in Montana; everyone who comes to a hospital receives treatment, regardless of their ability to pay.

However, in recent years, the number of people unable to pay for medical treatment has climbed dramatically. Uncompensated care in 1991 rose 19.7 percent over the previous year from \$7 million to \$8.4 million.

Enactment of SB 285 is a major step toward curbing this sharp increase.

Reform is also needed if we are address the continuing escalation of health care costs.

All of us are concerned about the high cost of health care. But, as the saying goes, "for every complex problem, there is a simple solution...and it's wrong."

I hope legislators will be wary of simple solutions to the health care cost problem. Attempts to avoid complex solutions to this very complex problem are one reason we are in the fix we're in now.

We recognize that serious cost containment is an essential part of health care reform, and we are eager to work with the Authority to develop a strategy that will bring this about.

We also would like to see the anti-trust provisions of this bill implemented immediately.

Unlike other parts of the economy, competition in health care does not reduce its cost. Instead it raises costs.

A number of hospitals are eager to cooperate and collaborate as part of their effort to hold down health care costs.

However, unless anti-trust reforms are enacted, they could run afoul of the law. Anti-trust reforms are one way we can attack the cost containment issue right now.

I also want to underscore the importance of protecting access to health care in rural areas. These communities are the most fragile component of our health care system. Failure to take into account their special needs could result in denying access to large segments of our state.

Finally, I hear rumors that MHA supports this bill -- rather than Sen. Yellowtail's -- as a way to block enactment of a single-payer system in our state. I want to make very clear where we stand on this issue.

We believe there are two alternatives for achieving health care reform. We also believe the only way to determine which one is in the best interests of our state is to initiate the process spelled out in the Franklin bill.

And we believe it is the Legislature's responsibility to choose between these alternatives. If the Legislature chooses a single-payer system, so be it.

This bill is the result of a historic process. It represents an effort by a wide variety of organizations and people representing consumer and provider groups, the Governor and Republicans and Democrats in the Legislature to develop a health care plan.

I applaud the leadership shown by Sen. Baucus, Gov. Racicot, Sen. Franklin and others who have participated in this process. None of us got everything we wanted. But we have made a major step toward achieving our goal of ensuring that every Montanan has access to high quality, affordable health care services.

SENATE HEALTH & WELFARE

EXHIBIT NO. 22

DATE 2-10-93

BILL NO. SB 285

SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

Madam Chairman, Members of the Committee, my name is Paul Hanson and I am the Administrator of Big Horn County Memorial Hospital and Nursing Home in Hardin, Montana. I am here today to testify and urge this committee to support Sen. Eve Franklin's Bill for "An Act Providing For Universal Health Care Access, Health Care Planning and Cost Containment; Creating the Montana Health Care Authority, Providing for the Powers and Duties of the Authority; Requiring a Statewide Universal Health Care Access Plan, etc al"

I recognize the need for and am in full support of Health Care Reform. Reform which allows for Universal Health Care Access and Cost Containment. Reform which will address duplication of services not only in the private sector, but also in the government sector. I believe every provider should have the opportunity to compete for available healthcare contracts which may reduce the cost of available healthcare services to our Montana residents.

I commend those individuals who are willing to sacrifice and create a Universal Health Plan for all Montanan's, but radical change could cost everyone more money in the long haul. How we deliver and pay for health-care in the years to come is a very complex issue. Efforts to achieve consensus on healthcare reform will take time and require difficult changes for all of us.

I would strongly encourage this committee to send the message out to every Montanan that Health Care Reform is a major issue, an issue that cannot and will not be taken lightly. Senate Bill 285 does not endorse "radical" change. It allows for Montana's best to formulate recommendations that will assist us making the right decisions to meet our health

care needs now and if future generations to come.

Thank you for your time and consideration.

Paul Hanson

Big Horn County Memorial Hospital and Nursing Home

PROPOSED AMENDMENTS TO SB 285

Proposed by the Montana Hospital Association

1. Title, line 18.

Following: "VITAL STATISTICS;"

Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY;"

2. Page 3, line 9.

Following: "cost-effective."

Insert: [new paragraph] "A statement of intent is also required because [sections 14 through 16] permit the authority to adopt rules relating the issuance and revocation of a certificate of public advantage for a cooperative agreement. The authority's rules must comport with the legislature's intent to provide the state, through the authority, direct supervision and control over applicant health care facilities, and it is the intent that this state direction, supervision, and control will provide state action immunity to groups of health care facilities that have a valid certificate of authorization under [Sections 13 through 18] in the event that such cooperative actions otherwise could be construed as in conflict with federal or state antitrust laws.

3. Page 5, line 3.

Following: "the authority."

Insert: "The attorney general is a non-voting, ex officio member of the authority solely for the purposes of studying and making recommendations concerning the impacts of state and federal antitrust laws on health care services in the state pursuant to [section 3] and approving and supervising cooperative agreements pursuant to [sections 13 through 18]."

4. Page 12, line 24.

Following: "authority"

Strike: "shall"

Insert: "may"

Following: "plans"

Insert: "additional"

Following: line 19

Insert: "NEW SECTION. Section 13. "Cooperative agreement defined. (1) "Cooperative Agreement" means a written agreement among two or more health care facilities for the sharing, allocation or referral of patients, personnel, instructional programs, emergency medical services, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services customarily offered by health care facilities.

"NEW SECTION. Section 14. Certification for cooperative agreement. 1. A health care facility may negotiate and enter into a cooperative agreement with one or more other health care facilities in the state if the authority determines the cooperative agreement is likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

2. (a) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage governing the cooperative agreement. The application must include a copy of the executed cooperative agreement and a description of the nature and scope of the cooperation contemplated by the cooperative agreement, including any consideration passing to any person under the terms of the cooperative agreement.

(b) The authority may adopt rules including but not limited to rules for the form and content of applications for a certificate of public advantage.

3. Within 90 days after receipt of a complete application for a certificate of public advantage, the authority shall grant or deny the application. When considered appropriate by the department, the authority may hold a public hearing within such 90 day period.

"NEW SECTION. Section 15. Reconsideration and appeal. (1) Applicants for a certificate of public advantage may request the authority to reconsider its decision. The authority shall grant the request if an applicant submits the request in writing and if the request is received by the authority within 30 calendar days after the initial decision is announced.

(2) A public hearing to reconsider must be held within 30 calendar days after the request is received unless the applicants agree to waive the time limit.

(3) The reconsideration hearing must be conducted pursuant to the provisions for informal proceedings of the Montana Administrative Procedure Act.

(4) The authority shall make its final decision and serve the applicants with written findings of fact and conclusions of law in support of the decision within 30 days after the conclusion of the reconsideration hearing.

(5) The applicants may appeal the authority's final decision to the district court as provided in Title 2, chapter 4, part 7.

(6) The department may by rule prescribe in greater detail the hearing and appellate procedures.

"NEW SECTION. Section 16. Standards for certification. The authority shall issue a certificate of public advantage for a cooperative agreement if it determines the applicants have demonstrated that the agreement is likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

"NEW SECTION. Section 17. Revocations of certificate of public advantage.(1) The authority may revoke a certificate of public advantage if it determines that the agreement is not resulting in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

(2) A certificate of public advantage may not be revoked without notice and an opportunity for hearing before the authority given as follows:

(a) Written notice shall be given the parties to the cooperative agreement for which the certificate of public advantage is proposed to be revoked not less than 120 days prior to the proposed revocation.

(b) If a party to the cooperative agreement submits a request for hearing in writing and the request is received by the authority within 30 calendar days after notice is mailed to the parties, the authority shall hold a public hearing to determine whether the certificate of public advantage should be revoked.

(c) A public hearing to determine whether the certificate of public advantage should be revoked must be held within 30 calendar days after the request is received.

(d) The hearing must be conducted pursuant to the provisions for informal proceedings of the Montana Administrative Procedure Act.

(e) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of the decision within 30 days after the conclusion of the reconsideration hearing.

(f) Any party to the cooperative agreement may appeal the authority's final decision to the district court as provided in Title 2, chapter 5, part 7. No revocation of a certificate of public advantage may become final until the time for appeal to the district court has expired.

(g) If a petition to appeal the revocation of a certificate of public advantage is filed, the revocation must be stayed pending resolution of the appeal by the courts.

(h) The authority may by rule prescribe in greater detail the hearing and appellate procedures.

(3) The authority may by rule establish reporting requirements for parties to a cooperative agreement for which a certificate of public advantage is in effect for the purpose of determining whether the agreement continues to be likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

"NEW SECTION. Section 18. Recordkeeping. The authority shall maintain on file cooperative agreements for which a certificate of public advantage is in effect. Any party to a cooperative agreement who terminates the agreement shall file written notice of the termination within 30 days after such termination.

Renumber: subsequent sections.

6. Page 22.

Following: "[Section 13(1) through (9)]"

Delete: "is"

Insert: "and [Sections 13 through 18] are"

STATE AUDITOR
STATE OF MONTANA



SENATE HEALTH & WELFARE

COMMITTEE NO. 24

DATE 2-10-93

BILL NO. SB 285

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

Mark O'Keefe
STATE AUDITOR

TESTIMONY OF STATE AUDITOR MARK O'KEEFE ON SENATE BILL 285 BEFORE
THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE ON
FEBRUARY 10, 1993

Madame Chair, members of the committee, I am State Auditor Mark O'Keefe.

I'm the state insurance commissioner, regulating the billion-dollar a year insurance industry in Montana. That includes more than 1,400 insurers and 12,000 producers and agencies -- an industry that is expected to provide the state general fund with \$30 million in premium tax revenue this fiscal year.

The insurance industry is an important component of this state's economy, and deserves fair regulation and competition. Consumers also deserve a fair product for their premium dollar.

My job is to regulate this industry in a fair manner so consumers receive the product they paid for and insurers and producers play ball on a level playing field and deliver the product.

We've looked at Senator Franklin's bill from that perspective -- in terms of our responsibility to help foster the relationship between consumers, insurers and producers.

When I read this bill in its introduced form, I was concerned. I think it asks me, as insurance commissioner, to accomplish tasks that simply can't be done in Montana because we simply don't have the data to do so.

I met with Senator Franklin and with representatives of the insurance industry and have drafted a set of amendments.

These amendments make the insurance portion of the bill workable. The amendments are based on model legislation used in other states, and are modified to fit Montana and to accomplish the purposes of this bill. If you adopt these amendments, I believe I can carry out the responsibilities that I will be assigned and do that at a reasonable cost.

The amendments provide significant reforms: They provide for portability and increased community rating, require that mandated benefits be part of the basic health insurance plan, narrow the range of allowable premiums and establish a reinsurance pool to keep the new plan financially solvent.

(more)

The cost of these amendments is similar to the costs projected in the fiscal note. The amendments add two councils, which will require some additional travel expense for members. But staffing and operational costs remain unchanged.

I might point out that I have other legislation that will provide non-general fund support for a life and health actuary in my office. If this legislation is successful, I will be able to reduce the general fund cost of this bill by \$70,000.

This amendment is like most compromises -- no one got everything they wanted. But I believe it is a workable plan and urge your adoption of the amendment and the bill.

I have asked my deputy insurance commissioner, Frank Cote, who has worked hard over the last few days with our staff, representatives of the insurance industry and Senator Franklin to draft the amendment, to walk you quickly through the amendment.

But before I do that, I want to note that I just returned from Washington, D.C., where insurance commissioners heard from Ira Magaziner, one of President Clinton's health-care advisers. Magaziner outlined six key points concerning the federal health insurance program:

Point #1 The president's plan will have managed competition within a budget.

Point #2 The program will be employer-based with help from the government.

Point #3 The program will provide security for all, be portable and insure that no person loses insurance because they lose a job or transfer from one job to another.

Point #4 The program must operate soon to cut costs.

Point #5 The program should be based on a system of personal choice with reliance on the private sector.

Point #6 The system must maintain quality.

Magaziner said a national board would set targets and establish a national health care package, but added that state or regional oversight would be allowed.

Magaziner and the president also said states should move ahead with their programs and we should not wait for the federal government's program to come on line.

Magaziner also said states should have more flexibility soon in the use of Medicaid funds, and that whatever programs the states put together must have universal access to include self-insureds.

Now, Frank Cote will walk you through our proposed amendments.

Thank you.

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STATE AUDITOR
STATE OF MONTANA

Exhibit #24
2-10-93
SB-285

Mark O'Keefe
STATE AUDITOR



COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

TO: Senator Eve Franklin
FROM: Mark O'Keefe, State Auditor
DATE: February 10, 1993
SUBJECT: Fiscal Impact of Insurance Amendments to SB 285

My office has prepared a fiscal note to SB 285 in the introduced version. The costs for the Auditor's Office are projected to be \$145,385 in FY94 and \$142,817 in FY95. The amendments that I am offering to the insurance portion of the bill do not change the costs materially. The staffing and operational costs remain the same. The amendments create two advisory councils, one to establish the basic benefit plan, the other to establish the reinsurance pool. Those councils have a significant amount of work to accomplish in FY94 and will incur travel and mailing costs. I project those additional costs to be \$28,000 in FY94 and \$16,000 in FY95. Bringing the total to \$173,385 in FY94 and \$158,817 in FY95. I have not included in those numbers the costs of my legal or administrative staff which is part of the agency's current level budget.

I have other legislation which would provide non-general fund support for a life and health actuary. If that legislation is successful, I would be able to reduce the general fund cost of this fiscal note by \$35,000 per year.

There have been questions raised regarding how the start-up funding will be provided for the reinsurance pool. The amendments allow for assessments to insurance companies offering coverage under this act to provide that funding. It also allows the Commissioner to borrow funds for costs if necessary. In either case, there will be no state expense related to the reinsurance pool.

53rd Legislature

LC 0144/01

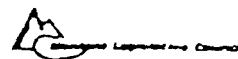
1 *Sen. H. J. Smith* BILL NO. *25* *W. Byron Nelson*
 2 INTRODUCED BY *Franklin B. Brown* *J. Lynne*
 3 *Van Tassell* *Moscoe C. Brown* *George C. Brown*
 4 *Blaylock* *L. Nelson* *Carl*
 5 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 6 HEALTH CARE ACCESS, HEALTH CARE PLANNING AND COST
 7 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 8 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 9 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
 10 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 11 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
 12 REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON
 13 LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH
 14 PLANNING REGIONS AND BOARDS; PROVIDING FOR THE POWERS AND
 15 DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
 16 UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR ~~HEALTH~~
~~INSURANCE REFORM.~~

A small employer health insurance act

17 TRANSFERRING TO THE AUTHORITY CERTAIN
 18 FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND
 19 ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS;
 20 AMENDING SECTION 50-15-101, MCA; AND PROVIDING EFFECTIVE
 21 DATES."

22 STATEMENT OF INTENT

23 A statement of legislative intent is required for this
 24 bill because [section 10] requires the Montana health care
 25 authority to adopt rules establishing a maximum of five



The original is stored at the Historical Society at 225 North Roberts Street,
 Helena, MT 59620-1201. The phone number is 444-2694.

The minutes from the February 10, 1993 meeting of the Senate Public Health, Welfare, and Safety Committee contained "Report of the Health Care Cost Containment Advisory Council" and "Phase II: Steps to Implementation" from Health Care for Montanans. The originals are stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

DATE 2/10/93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 285

Name	Representing	Bill No.	Check One Support Oppose	
Wally Henkelman	Mont. Nurses Assn	SB 285	✓	
Ed Grady	MT. MED. ASSOCIATION	"	✓	✓
J. Martin Burke	MT. Citizens Health Group	SB 285	✓	
L. L. White	ST. PATRICK HOSPITAL	SB 285	✓	
Doug Campbell	MSCA	SB 285	✓	
Clyde Dailey	MSCA + MUHC	"	✓	
Christian McKay	MUHC	"	✓	
Bill Olson	AARP	SB 285	✓	
Dr. Jeff Strickler	Am Assoc Pediatrics	285	✓	
Dr. Kathleen King	MT. Citizens Health Group	285	✓	
Donna Schumann	MT Citizens Health Group	285	✓	
Gloria Paladichuk	" " "	285	✓	
Howard P. Bailey	MT. Unif. Med. Soc.	285	✓	✓
JACK Molloy	M. M. A	SB 285	✓	
Peter Blouke	SRS	SB 285	✓	
John Cragg	MMA	SB 285	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

81

DATE 2-10-93SENATE COMMITTEE ON Public HealthBILLS BEING HEARD TODAY: SB 285

Name	Representing	Bill No.	Check One	
			Support	Oppose
John W. McMichael, M.D.	MMA	SB 285	✓	
Van Hake Nelson, M.D.	Health Care / Montanans	SB 285	✓	
Mike Schweitzer, MD	MMA	SB 285	✓	
Brian Ems	MT Medical Assn	SB 285	✓	
Jessa Klesh	Montana Farmworker Union	SB 285	✓	
Allyce Speech	Student Nurses of MT	SB 285	✓	
DAVE FORBES	myself	SB 285	✓	
Jim Meldeum	myself	SB 285	✓	
Robert J. Hill	Health			
	Task Force for Biomedical Information	285	✓	
Sue Hanson	MT	SB 285		
Suzy Holt	Task Force for Biomedical Information		✓	
Ken Eden	Citizen's Health Group		✓	
W. A. Nequed	" "	" "	✓	
Margaret Flynn	Citizen's Health Group	285	✓	
Made Cassidy	off	285	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: _____

Name	Representing	Bill No.	Check One	
			Support	Oppose
DAN ZITTEL	MT CHAMBER	SB 285	☒	☐
Judge Wright	TDHS	SB 285	☐	☐
CHRISTINE MANGIANTINI	League of Wm. Voters	285	☒	☐
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	SB 285	☒	☐
Richard Miller	MT State Library	SB 285	☒	☐
Steve Turkilevitz	MT AUTO DEALERS ASSN MT ASS Health Care Purchasers	SB 285	☒	☐
Bob Brown	Senads Dist 2		☒	☐
Col. Windsor	Deaconess Medical	S.B 285	☒	☐
Therell Butler Jr	Blue Cross + Blue Shield	SB 285	☒	☐
Peter Johnson	NFIB ^{WMT}	285	☒	☐
Michael Regnier	MT People's Action	285	☒	☐
Tom Hozgoal	Health Ins Assn. America	285	☒	☐
Lorna Frank	MT. Darn Bureau	285	☒	☐
Frederic Jacobson	Sen Dist 36	285	☒	☐
Melissa Case	Montana Peoples Action	285	☒	☐
John Guy	St. Peter's Comm. Hosp.	285	☒	☐

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: _____

Name	Representing	Bill No.	Check One	
			Support	Oppose
Staci Riley	MT Federation	SB ²⁸⁵	☒	☐
Angela Hume	State Farm Ins. Co	SB ²⁸⁵	☒	☐
Greg EKLUND	Montana Demo. Party	SB ²⁸⁵	☒	☐
Kate Cholewick	MT Women's Lobby	285	☒	☐
Dan Shea	MLIC		☐	☒
Russ Ritter	Wash Corp	285	☒	☐
Jamie Daggett	MT Catilwormen	285	☒	☐
Tom Ebery	St Vincent Hospital	285	☒	☐
Wendy K...	NSCA-MLIC		☐	☐
W. Keefe	State Auditor	285	☒	☐
Craig Smith	Mt. Peuch Assoc	285	☒	☐
Wendy E...	MT. Ret. & Assoc		☒	☐
Mary McEue	Mt. Dental Ass'n Mt. Clinical Mental Hlth Cnslrs	285	☒	☐
Don Judge	MT STATE AFL-CIO	SB ²⁸⁵	☒	☐
			☐	☐
			☐	☐

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

MONTANA SENATE 53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 10, 1993, at 6:30 p.m.

ROLL CALL

Members Present:

Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: Sen. Hager

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Laura Turman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 285, Questions from the Committee
Executive Action: None.

HEARING ON SB 285

Chairman Eck said this would not be a formal hearing, but the Committee would have the opportunity to ask questions there wasn't time for during the earlier hearing on SB 285.

Questions From Committee Members and Responses:

Sen. Rye said he would like some opinions as to how the health care crisis came about, and why the proponents from the medical community all stressed cost containment. Sen. Rye said the AMA (American Medical Association) previously fought involvement of the federal government, and "socialized medicine." Dr. McMahon, Montana Medical Association, said doctors are not getting richer. His income from Medicare, per case, has dropped 25% under the relative value system which the Association has asked be

incorporated into SB 285 as an amendment. Dr. McMahon said the remuneration procedure has changed, and some procedures have an extremely high remuneration. Now these procedures placed in the high reimbursement level don't occur. Under any reorganization system, there's not a provider who will not see a per procedure decrease in reimbursement.

Sen. Rye said he was implying that there is more self-interest on the part of medical providers in SB 285 than in SB 267. Sen. Rye said this is not a bad thing. Sen. Rye said he would not believe that the medical establishment was acting "purely out of altruism." Dr. McMahon said under a single-payor system that's immediately enacted, the United States has no experience other than the Medicare system, veterans system, and the public health system. Problems which may occur under a single-payor system are that those who are most in need now, the poverty stricken, those who can't afford insurance, will be most affected unless it is defined what will be paid for under this system. Dr. McMahon said there must be concentration on "what we know works," and there must be a system that does not pay for what does not work.

Sen. Rye asked Clyde Dailey to respond to his original question. Mr. Dailey said there are too many reasons to list "what went wrong," but significant factors include new, expensive technology, and a shift in emphasis from general practitioners to specialists. This has increased the cost, but has improved the care. There is a much more fractured system than before. Mr. Dailey said that "you couldn't run a business the way our health care system is being run today."

Chairman Eck said the Committee needs to focus on the facts more than the philosophy of health care reform.

Sen. Christiaens asked Dr. McMahon about elective surgeries being placed on a waiting list in a system such as Canada's. Dr. McMahon said it depends upon how the Health Care Authority establishes the Montana system. In Canada, there is generally a prioritization system of urgent, emergent and electorate. The vast majority of surgeries fall under the electorate category. Dr. McMahon said there are thirteen different Canadian systems and these systems are probably good and cheap, but they are not fast. The American system is good and fast, but not cheap.

Sen. Christiaens asked Dr. McMahon if he foresaw all physicians accepting Medicaid payments as this evolves. Dr. McMahon said he didn't see how physicians could stay in business accepting only Medicaid payments. Physicians' expenses exceed the costs of the Medicaid payments, and that's why their amendment suggests there be recognized an adjustment of insurance companies and patients' payments.

Sen. Christiaens asked Dr. McMahon about costs varying by provider. Dr. McMahon said he was referring to the adjustments in payment by Blue Cross, for example, and Medicaid. A patient

with multiple providers, for example, might pay different bills for different one-hour sessions. Dr. McMahon said there must be something in the system to recognize differences in provider's educational background, and expense differences.

Chairman Eck asked Maureen Testoni from Sen. Max Baucus's office to respond to questions regarding waivers, specifically Maryland establishing waivers that may apply to everyone. Ms. Testoni said that Maryland has a waiver for Medicare and Medicaid which means that they can do what they want with those funds. Maryland has established an "all-payor reimbursement system" for hospitals which means that all payers pay the hospital according to a set fee schedule. Ms. Testoni said this is the language in SB 285.

Chairman Eck asked Ms. Testoni if the state set the fees, and Medicaid and Medicare agree to pay them. Ms. Testoni said that was true, the state sets the fees, but they do it in negotiations with the hospital. Maryland was able to get the waivers because their legislation is "tightly written", and because both Medicare and Medicaid know this is a way to keep hospital expenses from increasing as quickly as they are in other states. Ms. Testoni said regarding an ERISA waiver, Maryland negotiated with the self-insured businesses. Federal law states that a state cannot require businesses to follow a state fee schedule, but because Maryland has such a good system in place, the self-insured business agreed to go along with the rates. Therefore, an ERISA waiver was not needed.

Chairman Eck said they have heard that waivers granted to one state will be granted to other states, and asked Ms. Testoni to what extent that would apply. Ms. Testoni said President Clinton has made it clear that he is committed to making it easier for states to get waivers. However, states will still have requirements that must be met in order to get those waivers, for example, that this is a serious cost-control program.

Sen. Klampe asked Clyde Dailey what provisions in his plan (SB 267) there are for the over-utilization of services. Mr. Dailey said they struggled with "first dollar coverage." Within the Health Care Authority there must be designed the ability for providers to recognize patients who are attempting to over-utilize the system.

Sen. Klampe asked Mr. Dailey if there were no plan so far. Mr. Dailey said the existing plan is to let the Authority look at copayments or premiums as a deterrent for over-utilization. People must contribute something, or there will be a chance of over-utilization.

Sen. Klampe asked Mr. Dailey what procedures would not be covered under his plan, or would every procedure attempt to be covered. Mr. Dailey said cosmetic surgery was specifically eliminated where it wasn't absolutely vital to the patient. The Authority will have the flexibility to leave it to the providers to

designate what they feel are "elective procedures." That's where it must begin.

Sen. Klampe asked Mr. Dailey if there would be "rationing" under his system. Mr. Dailey said there is "rationing by the pocket book" right now.

Sen. Klampe asked Mr. Dailey what Canada had done about the two problems he brought up. Mr. Dailey said patients in Canada wait.

Sen. Towe asked Sen. Franklin about Section 14 in SB 285 regarding the transfer of vital statistics to the Health Commission which was amended out of the bill. Sen. Franklin said the burden of vital statistics was not needed, and did not add anything to the bill providing that there is some coordinating language allowing accessibility to vital statistics as needed.

Sen. Towe asked Sen. Franklin what was the intent of Section 13, what was being accomplished regarding small employer group health insurance. Sen. Franklin said the guiding principles of continuity of coverage, community rating, portability, open enrollment so as not to limit those with preexisting conditions.

Sen. Towe said he had concerns regarding the database in Section 12, Paragraph 7, "the duties of the Authority under this section may not be construed to allow the Authority to use the database to manage a corporate health care facility in a manner that usurps the appropriate powers of the board of directors of the facility." Sen. Franklin said there were concerns about the autonomy of agencies. For example, would the data collection component of SB 285 dictate policy to agencies in terms of how that agency was run.

Sen. Towe asked Sen. Franklin if the reverse were likely to be true, that because of this statement and the prohibition of using the data to interfere with the management of the hospital that somehow the data will be used to limit the action of the Authority. Sen. Franklin said that was not the intent, and she did not read that into that section of the bill.

Chairman Eck asked Rick Hardin to speak about the task force on data. There is a section in Sen. Nathe's bill which was drafted by the task force. Mr. Hardin asked the project director to discuss it.

Mike McInerney, Montana Cooperative Center for Health Statistics, said the Center arose out of a grant application made by the state to the Robert Wood Johnson Foundation's Information for State Policy Center. The state of Montana was awarded a planning grant of \$150,000, and the stipulation of the Robert Wood Johnson Foundation was that the planning grant formulate a policy generation unit for health care which is data based. The Center, a group of health data specialists, was appointed by Governor Stephens. The result of the project will be that in May, they

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

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will submit a grant to the Robert Wood Johnson Foundation for implementation funding, up to \$350,000 for each of four years. Sen. Nathe's bill takes up their concerns in the direction of the work the Center has done.

Chairman Eck asked Mr. McInerney how his proposals fit into the sections dealing with data collections sections of these two bills (SB 267 and SB 285). Chairman Eck asked Mr. McInerney if the Center's language could be amended into these bills. Mr. McInerney said SB 267 and SB 285 take a narrower view of data collection than the Center. There are many aspects to data collection, including volumes of data being collected in various public health programs. In order to make the most utility of all the data, all pieces should be tied together into one program that can assist health policy. Sen. Nathe's bill does combine most data aspects with health utilization and health cost into one central program. Mr. McInerney said there is tremendous overlap, 50% or more.

Chairman Eck asked Mr. McInerney if he was working on policy determination. Mr. McInerney said they were working on a system whereby policy determination can be taken. They are trying to put together a data system which will answer policy questions.

Chairman Eck asked Mr. McInerney if it would be helpful to the Health Care Authority. Mr. McInerney said it would be.

Sen. Towe asked Jim Ahrens about if a preferred provider were the subject in SB 285, Section 8, Pages 12 and 13. Mr. Ahrens said that language could reference managed care or an HMO as well. It could be a variety of things.

Sen. Towe asked Sen. Franklin if that were her understanding. Sen. Franklin said it was.

Sen. Towe said Page 8, Line 13, references things which the Health Care Authority may modify, for example, to take into account population increases or decreases and "cost beyond the control of the health care providers." Sen. Towe asked Sen. Franklin to what that referred. Sen. Franklin said there were concerns about events over which hospitals or physicians have no control, and they felt there should be some language in SB 285 to address this.

Dr. Chet Strickler said that two years ago the federal government put a \$50.00 per bottle surcharge onto a certain vaccine. This was something that happened suddenly and was beyond the physician's control.

Dr. Jack McMahon said that drugs involved with treating cancer may cost as much as \$10,000.00 to \$15,000.00 per shot, and this is totally out of the control of the health care provider.

Sen. Towe said that somewhere along the line there is a provider

responsible for the cost increases. Dr. McMahon said liability providers, for example, are not currently under the definition of a provider. Physicians have a duty to inform the public of effectiveness of chemotherapy, but some patients will insist on very expensive but ineffective treatments. These high costs are out of the physician's control.

Sen. Towe said that Page 8, Part B of SB 285 states that a system "may" include prioritization of services. Sen. Towe asked if this were intended to sound like the Oregon Plan of prioritization. Sen. Franklin said the "may" was very meaningful. Physicians were concerned that they would have no options, and prioritization was a way that they would have some guidelines. The "may" includes other guidelines such as clinical protocol guidelines as well. This is one way to limit demand and physicians wanted the option to pursue that.

Sen. Towe asked Sen. Franklin if prioritization might include an Oregon Plan approach. Sen. Franklin said prioritization might include clinical protocol, or preventive care. At least there are options to develop.

Sen. Christiaens asked Jim Ahrens to address the anti-trust issue. Jim Ahrens said they are concerned with violations of the Sherman Anti-trust Act, for example, in discussing budget proposals. Mr. Ahrens said it is extremely crucial that hospitals work together under state supervision so they are not accused of dominating the market, which they do not want to do.

Sen. Christiaens asked about "gate-keeper" options, and if this were an effective way to manage this. Dr. McMahon said a gate-keeper system means that every patient is assigned to a primary care physician. Before a patient could be referred to a specialist, it must go through the primary care physician.

Sen. Christiaens asked Dr. McMahon if it had any merit in determining if something needing immediate attention. Dr. McMahon said that depends upon who the gate-keeper is and what the case is. The Stephens program study showed that 35% of Medicaid population in Helena considered the emergency room their primary care source. A gate keeper system would go a long way to keep down Medicaid costs. He would recommend that the gate keeper system be expand to all Medicaid patients.

Clyde Dailey said that there are a variety of mid-level practitioners who should not be overlooked who could act very effectively in this fashion, for example, nurse practitioners or physician assistants. This is important especially for rural areas where it is difficult to attract physicians.

Dr. Chet Strickler said he is a gate-keeper as a pediatrician and it works well. Medicaid has a just begun gate-keeper system called Passport to Health, and significant savings in health care costs are anticipated.

Sen. Christiaens said he has worked with this, and it might be something which could be put into SB 285 because it has a lot of merit and can save a lot of money.

Dr. Strickler said a Medicaid "medical home" is attempting to be established to serve children so they have a place to come for primary care. There is significant savings in health care costs as well as improved health care.

Sen. Rye asked if SB 285 would provide incentives for physicians to move elsewhere or to come to Montana. Dr. McMahon said that every time a physician reads SB 285, they think "we've all become socialists." There is an ongoing program to educate the physicians of Montana about why they support SB 285. Dr. McMahon said the fact is that changes are going to happen nation-wide. There is an underinsured need to be addressed, as well as the wasteful spending in health care which must stop. Hospitals and doctors cannot be told what procedures to do and not to do, but they must be told what procedures will be paid for, or not paid for under this program.

Sen. Rye asked Dr. McMahon how he felt about SB 267 in this regard. Dr. McMahon said business cannot continue in its current manner, regardless which bill is addressed.

Chairman Eck asked Frank Cote to address the insurance issue.

Frank Cote, Chief Deputy to the Insurance Commissioner for the State of Montana, provided written testimony. (Exhibit #1)

ADJOURNMENT

Adjournment: Chairman Eck said the only Executive Action that would be taken on Friday, February 12, would be to decide which bill, SB 267 or SB 285, to work with and amend. Chairman Eck adjourned the meeting.



SENATOR DOROTHY ECK, Chair



LAURA TURMAN, Secretary

DE/LT

ROLL CALL

6:30

SENATE COMMITTEE Public Health DATE 2-10-93

[illegible]

DATE 2-10-93BILL NO. SB 285

Madam Chair, members of the committee, for the record my name is Frank Cote. I am the Chief Deputy Insurance Commissioner for the State of Montana.

Our office looked at model legislation from many states. After thorough review and adaptation to Montana's laws and unique situations, we would like to offer the following amendments, which I would like to walk you through. We have created Small Employer Health Care Reform, which I will discuss in a minute.

On page 5 of Senator Franklin's bill, we have added the Commissioner of Insurance to the Montana Health Care Authority as an ex-officio member. This will allow us to have an easier flow of information between our department and the Health Care Authority. Also on page 5 we have added Health Service Corporations in order to include the Blues. On page 18, we have removed Section 13 and have replaced it with Small Employer Health Insurance Reform. New Section 14 states the purpose of the reform.

Generally, the purpose is to promote availability of health insurance coverage to small employers regardless of health status or claims experience, and to the overall fairness and efficiency of the small employer health insurance market.

Section 15, page 1 of the amendments deals with definitions. Of note here, on page 7 of the amendments is the definition of small employer. The definition lists a small employer as one employing at least three people and no more than 25.

Section 16 on page 8 is the applicability and scope of the Act. Section 17 establishes the classes of business.

Section 18 on page 9 deals with the restrictions relating to premium rates. Of importance here is under Section 1, Subsection (a) which says: "The index rate of one class of business may not exceed another class by 20%." And also, Subsection (b)(i) which says: "Premium rates charged in a rating period may not exceed the index rate by 25%." It's also important to note here that if the managed healthcare authority reaches its cost containment goals by 1999, this percentage will drop to 20%.

Section 19 on page 15 deals with renewability of coverage. Important to note there is that a health benefit plan subject to the provisions of Sections 13 through 27 is renewable with respect to all eligible employees or their dependents. With some exceptions including non payment of premiums or fraud or misrepresentation of the small employer. Also, at least 180 days prior to non-renewal of any plan, the carrier must provide notice of that effect to the small employer.

Section 20 on page 17 deals with the availability of coverage. Each carrier shall offer at least two benefit health plans: one plan a basic plan; and one plan a standard plan. Benefit plans

may not exclude benefits because of a preexisting condition for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage.

Section 21 on page 21 deals with the reinsurance program. There is a non-profit entity known as the Montana Small Employer Health Reinsurance Program. The program operates subject to the supervision and control of the board. the board consists of 9 members appointed by the Commissioner plus the Commissioner or a designated representative who shall be an ex-official member of the Board. It is the Board's duty, within 180 days of appointment, to submit a plan of operation to the commissioner for equitable administration of the program. Commissioner, after notice and hearing, may approve the plan. If the Board fails to submit a program within 180 days, the commissioner shall after notice and hearing adopt a temporary plan of operation. This plan must establish the procedures of operation.

Section 22, page 29 is the Health Benefit Plan Committee. This gives the Commissioner the authority to appoint a Health Benefit Plan Committee. It is this committee's responsibility to recommend benefit levels of coverages by small employers carriers. Benefit plans must include the cost effective measures such as utilization review of health care services.

Section 23 on page 31 deals with periodic market evaluation of Sections 13 through 27. In general, the board in consultation with the committee must report to the commissioner the effectiveness of the Small Employer Health Care Reform.

Section 24 waves certain state laws but does not include waiver of mandated benefits. Section 25 discusses administrative procedures in the adoption of rules. Section 26 is the standards to ensure fair marketing.

Section 27 on page 34 deals with the restoration of terminated coverage.

Madam Chair and members of the committee these amendments take a significant step towards health care reform, and we feel we can effectively implement to the benefits of Montana insurance consumers.

MINUTES

MONTANA SENATE 53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 15, 1993, at 1:00 p.m.

ROLL CALL

Members Present:

Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)

Members Excused: Sen. Tom Towe

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Laura Turman, Committee Secretary
Tom Gomez, Legislative Council

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 291
Executive Action: SB 285 - continued to 2/17

HEARING ON SB 291

Opening Statement by Sponsor:

Sen. Steve Doherty, Senate District 20, said SB 291 is the result of problems the mental health community has been having in getting paid in a timely fashion for their services. SB 291 will do three things for utilization review. First, the review should be done by a peer. Second, insurers should not ask for additional information as a way of slowing payment for services. And, third, additional information should be limited to the information regarding the care and treatment, and this information should be confidential and anonymous.

Proponents' Testimony:

Sen. Christiaens asked Mr. Hopgood who determined what information was "reasonably necessary" in the review of a case. Mr. Hopgood said it is difficult to define, but there is a certain degree of common sense in the insurance industry and the mental health industry.

Sen. Christiaens said what he meant was that there was protection already there regarding those decisions.

Sen. Rye asked Dr. Kohlstaedt about physical ailments being equally embarrassing, but insurance companies must know about them. Dr. Kohlstaedt said there are things that are so private, they are not at all like a physical ailment. She said that the issue is not confidentiality, but anonymity.

Dr. John Platt said in the case of mental diagnosis, there is a degree of personal information, but the case record may be filled with much more personal information, for example, family history.

Closing by Sponsor:

Sen. Doherty said Tom Hopgood's suggestion concerning the chiropractors was a good one to incorporate into SB 291. The issue of peer review should be discussed, as should utilization review.

EXECUTIVE ACTION ON SB 285

Discussion:

Susan Fox, Legislative Council, provided a memorandum regarding the Montana Hospital Association Amendments from David Niss who drafted SB 285. (Exhibit #5) Ms. Fox also provided copies of the Montana Hospital Association's amendments, (Exhibit #6), and went over them.

Chairman Eck said the suggestion was that, at the bottom of Page 2, (anti-trust) be left as a study for the Authority.

Ms. Fox said "anti-trust" is briefly addressed, but the Committee could further define it.

Sen. Christiaens said the amendments are complicated.

Sen. Franklin said Martin Burke, the chair of the committee on health care did come from Missoula. There are some amendments that could be addressed by the Committee today.

Martin Burke said that he and Clyde Dailey had a list of changes the supporters of SB 267 would suggest to SB 285.

Clyde Dailey passed out a copy of SB 285 with the suggested amendments from Sen. Bill Yellowtail's bill, SB 267. Clyde Dailey went over the amendments, which appear in smaller type. (Exhibit #7)

Sen. Eck asked Mr. Dailey and Mr. Burke to address the major issues to be addressed by the amendments.

Mr. Burke said SB 267 contains a general statement about health care policy. In defining a single-payor plan, SB 267 identifies a range of criteria which must be addressed. Mr. Burke said most of the criteria should be addressed whether there is a single-payor plan or a regulated multi-payor plan. Therefore, he proposed that items in SB 267 relating to single-payor issues which are not in SB 285 be added. Mr. Burke said both plans ought to contain a broad range of provisions, so they will expand the definitions in SB 285. In SB 267, the responsibilities of the regional planning boards are detailed to a greater extent than the responsibilities of the regional planning boards under SB 285. Mr. Burke said it was fine to expand details of boards' responsibilities. These changes are "indeed friendly amendments," because they provide greater and helpful detail.

Mr. Dailey said that was the intent. The issue of "cost containment" was not addressed because compromise already existed.

Mr. Burke said there are some disagreements, such as supporters of SB 267 would like board members to be full-time state employees. Mr. Burke said that his committee opted not to pay board members.

Mr. Dailey said they wanted paid full-time board members because they had concerns that ex-officio might "dominate" a volunteer board.

Mr. Burke said regarding the state health care resource management plan there is disagreement. In SB 267, there is an inventory of items, information, which must be addressed. Mr. Burke said that in developing a health care resource management plan, the Authority will have to look at different types of information.

Chairman Eck asked if the items in the resource management plan in SB 267 were listed in the database information system. Mr. Burke said that didn't make a difference. The information data provisions are the same in SB 267 and SB 285. There is an inventory of items to be addressed by the Health Care Authority in the development of the resource management plan, and that is consistent.

Mr. Dailey said the inventory gives the Authority direction.

Chairman Eck asked about the issue of prescription drugs as a

health care item. Mr. Burke said they agree with Sen. Yellowtail, that under the cost-containment provisions there ought to be specific mention of pharmaceuticals. The language in SB 285 was broad enough to cover pharmaceuticals, but they agree that there should be no doubt. SB 267 also asks for a study of pricing of drugs; if the date were pushed back from November 1994 to 1996, then they would agree on that issue. Mr. Burke said there was strong agreement concerning cost containment, and global budgeting.

Mr. Dailey agreed.

Sen. Klampe asked Mr. Burke and Mr. Dailey if they could walk through the bill with the Committee.

Susan Fox asked if Mr. Burke and Mr. Dailey had considered the Insurance Commissioner's amendments. Mr. Dailey said they had not been addressed.

Chairman Eck provided the Committee with a list of comparisons of insurance reform legislation. (Exhibit #8) Chairman Eck said the Committee would not address this issue at this hearing.

Mr. Burke said they could go through the amendments provided by Mr. Dailey. (Exhibit #7)

Mr. Burke said on page 3, the small print, regarding the "statement of health care policy", they do not disagree with this statement. On page 5, in the small print, there is disagreement concerning the representation of consumer groups. But the Committee could say that there should be at least one person representing consumer groups on the Authority.

Mr. Dailey said there should be mandated consumer representation on the Health Authority.

Chairman Eck asked if this would be true for whatever legislation the Committee chooses. Mr. Dailey said that was true. He had concerns that providers could dominate the process.

Mr. Burke said the committee he chaired discussed at length who should be on the Authority, and they opted not to define the members, but to leave it to the majority leaders of the House and the Senate.

Chairman Eck said that during Executive Action, this would be one of the first issues addressed by the Committee.

Mr. Burke referred to page 7, in the small print, the language regarding "executive director" and the authority of the board to hire consultants. They are in agreement, except for the language referencing "quasi-judicial" powers. They opted to eliminate this term, and Clyde Daily agreed to that.

Mr. Dailey said the point to be made is that the Board is not delegating its authority rather than doing it itself.

Chairman Eck asked about the authority of the Board to make decisions if it is not "quasi-judicial." Mr. Burke said the intention was not to cut the authority of the Board.

Mr. Dailey said later in SB 285, it is stated that the Board has subpoena powers, and that is why he is not uncomfortable with striking "quasi-judicial."

Mr. Burke said on Page 8, there is language about making the Board members full-time employees, which he would not choose to include. Mr. Burke said Pages 9, 10, 11, and 12 are all taken from SB 267, and there are provisions which address a single-payor system. Here, they suggest a list of requirements for a single-payor and a multi-payor, because the requirements will be, for the most part, the same.

Chairman Eck asked Mr. Burke if he wanted one general section of requirements, and then anything that is specifically applicable. Mr. Burke said that in SB 285 it states that there shall be a single-payor model and a multi-payor model and "the following requirements shall apply to both." This can be expanded.

Chairman Eck asked Mr. Burke if there were adequate definitions for both single-payor and multi-payor. Mr. Dailey said they did not attempt to define a regulated multi-payor system.

Chairman Eck suggested that they look at Sen. Nathe's bill because it has a couple of good definitions.

Mr. Burke said by "regulated multi-payor," they are only suggesting that any private payors are subject to a range of requirements which are delineating in SB 285.

Mr. Dailey said it would be broad and general, but it was necessary to include those requirements.

Mr. Burke said on Page 13, the indented language was an effort to spell out "expenditure targets," they agree to add the specific language. Mr. Dailey said they agreed on this issue.

Mr. Burke said SB 267 provides for the possibility of health care bargaining groups, and he does not disagree with that because it is one more mechanism for containing cost. Mr. Burke said he has no problems with health care bargaining groups, and the Authority assisting in those groups.

Sen. Christiaens asked if Mr. Burke were talking about preferred provider groups. Mr. Burke said he had not thought of it as preferred provider arrangements. He said he has no problem with the Health Care Authority assisting in discussions among two hospitals, for example, but he would go no further. There are

"big traps" with preferred provider arrangements.

Sen. Christiaens said there are about five different bills which address preferred provider organizations. There is also a bill which addresses a "willing provider," and he has concerns that there be consistency.

Mr. Dailey said on Page 18, Section 9 there is a definition of "health care provider bargaining groups." They are happy to amend this language if the Committee finds it necessary to do.

Sen. Christiaens said this is an area that needs to be looked at closely.

Mr. Burke agreed with Sen. Christiaens and said that he emphasizes the term "may" instead of the term "shall" in that section. On Page 15 and 16, there is language from SB 267 which details the factors which must be considered when creating a health care resource management plan statement. SB 267 defines a range of factors which must be identified. Mr. Burke said he agrees with this because it is a practical matter.

Mr. Dailey said the reason this language is included is that Montanans for Universal Health Care put a lot of effort into what should be included, and they feel it is comprehensive.

Chairman Eck said the decision before the Committee is how much detail to be included in the bill.

Mr. Dailey said that language addresses the use of out of state facilities by Montana residents, which they felt was important.

Mr. Burke said he agreed that the state Health Care Authority must consider the regional health care resource management plans, but it doesn't necessarily have to adopt those plans recommended by the regional panels.

Mr. Dailey said that on Page 16, "Medicaid" and "Medicare" was added under (ii) because President Clinton may give states flexibility concerning Medicaid and Medicare.

Mr. Burke said the language on Page 17 simplifies billing and claims. On Page 18, health care bargaining groups are addressed. Pages 19, 20, and 21 address anti-trust provisions from SB 267. Because they envisioned the Health Care Authority developing the plans and returning to the legislature with legislation for a single and a multi-payor plan, they saw no reason to go into detail concerning "anti-trust." Rather, SB 285 charges the Authority with developing the necessary anti-trust plan which would part of either a single-payor or a multi-payor plan. SB 267 provides anti-trust legislation immediately, and this is a "judgment call" the Committee will have to make.

Mr. Dailey said their attitude was "the more we can do now, the

less will have to be done in two years," and that is why SB 267 has anti-trust language.

Mr. Burke said he agrees with Mr. Dailey, and they have no problem with anti-trust legislation going into effect immediately. Page 23 established the health care planning regions, and all of that language is taken directly from SB 267. Sen. Yellowtail's bill would define the health care regions by county, and SB 285 states that the health care regions shall be based primarily on referral patterns. The notion of defining the regions is fine.

Sen. Franklin said there is a set of amendments from the Health Department, and the argument for getting the regions defined in the bill is so that the Authority doesn't spend too much time defining the regions.

Chairman Eck said they were very standard regions which are used throughout state government.

Sen. Christiaens said they were the same as the mental health regions.

Mr. Dailey said they were changed a little bit, because the eastern region with 17 counties was too large. Also, there is language in the bill to allow a county to petition out of one region and into another.

Mr. Dailey said the whole Page 24 should be removed.

Mr. Burke asked the Committee to look at SB 285 and the establishment of the regional boards. Pages 25 and 26 provide more detail to the creation of the regional boards, and he agrees with this language. The next set of small type, Section 16, addresses health insurance insurer cost management plans and is intended to encourage the insurance industry to participate in the overall planning process by coming forward with a cost management plan. Mr. Burke said he wasn't sure how this would work.

Mr. Dailey said the idea behind it was that the insurance companies must address the issue of cost containment over the next two years.

Mr. Burke said the final section is definitional.

Chairman Eck said there was still a request from the Department of Health that the bill specify that the state have just one health database system, and they have language they would like included.

Mr. Burke said he had no problem with this.

Chairman Eck said that the particular issue is that they have

finished the first planning phase of a Robert Wood Johnson grant, and they have the next one to turn in in May, and they need the assurance that there will be a unified system.

Mr. Burke said they were finished with the overview, and that he was satisfied with the result for a workable compromise. They favor small group insurance reform as a first step.

Chairman Eck asked Susan Fox and Tom Gomez if they could break this down into manageable amendments for the next Committee meeting.

Tom Gomez, Legislative Council, recommended that there be a substitute bill, by striking everything after the enacting clause, so that there is a clean, easy to understand text. Changes won't be seen, but it would be difficult to precede through this otherwise.

Susan Fox, Legislative Council, said before this is done, there needs to be agreement about which amendments should be included and which should not. Ms. Fox said she has five sets of amendments so far.

Chairman Eck said that when the Committee meets again, preliminary action must be taken.

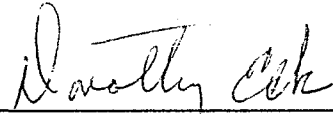
Sen. Christiaens asked Ms. Fox if she had the amendments regarding anti-trust language. Ms. Fox said she did not have specific amendments.

John Flink, Montana Hospital Association, said they would get their attorney to draft the amendments to give to Ms. Fox.

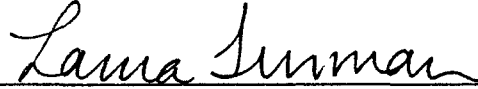
Chairman Eck said the Committee would have to decide if they are going to adopt those amendments. Also, these amendments could be left to the House. Chairman Eck said the Committee may have to meet on adjournment on Thursday, February 18. She said all amendments from this hearing would be faxed to Sen. Towe.

ADJOURNMENT

Adjournment: Chairman Eck adjourned the hearing.



SENATOR DOROTHY ECK, Chair



LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-15-93

[illegible]

MEMORANDUM

TO : Susan Fox

FROM: David Niss

RE : Amendments Proposed to SB 285 by the Montana Hospital
Association

DATE: February 13, 1993

Several days ago you asked for my assistance in reviewing the amendment proposed by the Montana Hospital Association to SB 285. This memorandum constitutes the results of my review.

The amendments proposed by the Association that I reviewed would: (1) delete a mandatory requirement that the Montana health care authority include in its universal access plans proposed legislation allowing providers and consumers to negotiate agreements, and make the inclusion of that legislation discretionary with the Authority; and (2) insert 6 new sections of law requiring the issuance of certificates of public advantage to health care providers apparently authorizing those providers to enter into what might otherwise be classified as anticompetative agreements with other health care providers. The proposal by the Association also provides for revocations of the certificates and an appeal process.

It is unclear from the Association's proposal how the authority's proposed legislation, which under the Association's proposal is allowed rather than mandated to be proposed by the Authority as part of the access plans, would supplement or coordinate with the Association's proposed amendments.

The importance of Section 8, subsection (3) of SB 285 (page 12, line 20 through page 13, line 7) is to give the authority ample opportunity and reason to conduct a study to determine the effect of federal and state laws governing anticompetative business arrangements on the health care industry. The effect of these laws has been considered so substantial by other states enacting health care reform measures that some of those states, such as Minnesota, have enacted statutes exempting under certain conditions agreements such as those contemplated by the Hospital Association from the effect of those state and federal antitrust laws (see, Ch.549, sec.14, Minn. Laws 1992). The effect of exemptions such as that enacted by Minnesota is to bring otherwise anticompetative agreements within the scope of what is called the "state action" immunity from the Sherman Antitrust Act, 15 U.S.C. sec. 1, et sec.

The theory of "state action" immunity from the Sherman Act is a judicially created immunity first announced by the United States Supreme Court in Parker v. Brown, 317 U.S. 41 (1943), and later clarified in California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97 (1980). In Midcal, the Court found that a state regulatory scheme could be the basis for antitrust immunity if that scheme satisfied a two-part test. First, the scheme had to be founded upon a state policy "clearly articulated and affirmatively expressed" allowing anticompetitive conduct. Second, that state had to provide for active supervision of the anticompetitive conduct allowed by the state policy. Midcal, 445 U.S., at 105. Thus, in order for agreements between health care providers in Montana to be immune from Sherman Act enforcement, the state regulatory scheme must satisfy the two pronged test of Midcal.

It's clear from a reading of the amendment submitted by the Hospital Association that the Association's proposal alone does not satisfy the Midcal test. Thus, if no other legislation were enacted to implement a "state action" immunity scheme other than the amendment proposed by the Association, health care providers agreeing with other health care providers to fix the prices of health care services would be found in violation of the Sherman Antitrust Act. This is because the proposed amendment contains no clearly expressed state policy allowing the contemplated anticompetitive conduct, and may not provide sufficient guarantees of active state supervision of the price fixing agreements except through the rules authorized but not required by section 17, subsection (3) of the proposed amendment. You may wish to compare the language of the Association's proposal with SB 267, section 26, which in my judgment much more clearly satisfies the Midcal test.

The issue that the Association's proposed amendment presents to the Senate Public Health Committee is whether to (1) adopt the Association's proposed amendment, hoping that legislation recommended by the health care authority in the plans to be presented to the legislature on October 1, 1994 will contain the other details of a state regulatory scheme satisfying the Midcal "state action" immunity requirements, (2) reject the amendment and hope that one complete scheme is presented in those plans, or (3) amend the Hospital Association's proposal sufficiently to be sure it satisfies the Midcal requirements, and then adopt the proposal.

My recommendation is that the Committee not adopt the Association's proposal, and that the study and recommendations of the health care authority be left to address this issue. The reasons for this recommendation are: (1) there is no necessity to adopt any regulatory scheme offering "state action" immunity at this point in time, given the structure of SB 285, as other pieces of the universal access puzzle will not fall into place until the 54th Legislature acts on the authority's plans; (2)

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adoption of the Association's proposal at this time would to some degree preempt the work of the health care authority, which may decide there is either no necessity at all for "state action" immunity in Montana given the other features of the plans to be presented to the legislature, or that a state regulatory "state action" immunity scheme must be structured much differently than the Association proposes, and (3) there is no provision in the Association's proposal for agreements between providers and consumers, authorizing what has been called in other states health insurance purchasing cooperatives (HIPCs) or health insurance networks, under which agreements between providers and consumers would receive the benefits of "state action" immunity. Such a scheme, again, should be the province of the authority's study and legislation now mandated by section 8 of SB 285 to be included in the authority's report to the legislature.

If you have any questions concerning the foregoing, please advise me.

PROPOSED AMENDMENTS TO SB 285

Proposed by the Montana Hospital Association

1. Title, line 18.

Following: "VITAL STATISTICS;"

Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY;"

2. Page 3, line 9.

Following: "cost-effective."

Insert: [new paragraph] "A statement of intent is also required because [sections 14 through 16] permit the authority to adopt rules relating the issuance and revocation of a certificate of public advantage for a cooperative agreement. The authority's rules must comport with the legislature's intent to provide the state, through the authority, direct supervision and control over applicant health care facilities, and it is the intent that this state direction, supervision, and control will provide state action immunity to groups of health care facilities that have a valid certificate of authorization under [Sections 13 through 18] in the event that such cooperative actions otherwise could be construed as in conflict with federal or state antitrust laws.

3. Page 5, line 3.

Following: "the authority."

Insert: "The attorney general is a non-voting, ex officio member of the authority solely for the purposes of studying and making recommendations concerning the impacts of state and federal antitrust laws on health care services in the state pursuant to [section 3] and approving and supervising cooperative agreements pursuant to [sections 13 through 18]."

4. Page 12, line 24.

Following: "authority"

Strike: "shall"

Insert: "may"

Following: "plans"

Insert: "additional"

Following: line 19

Insert: "NEW SECTION. Section 13. "Cooperative agreement defined.

(1) "Cooperative Agreement" means a written agreement among two or more health care facilities for the sharing, allocation or referral of patients, personnel, instructional programs, emergency medical services, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services customarily offered by health care facilities.

"NEW SECTION. Section 14. Certification for cooperative agreement. 1. A health care facility may negotiate and enter into a cooperative agreement with one or more other health care facilities in the state if the authority determines the cooperative agreement is likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

2. (a) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage governing the cooperative agreement. The application must include a copy of the executed cooperative agreement and a description of the nature and scope of the cooperation contemplated by the cooperative agreement, including any consideration passing to any person under the terms of the cooperative agreement.

(b) The authority may adopt rules including but not limited to rules for the form and content of applications for a certificate of public advantage.

3. Within 90 days after receipt of a complete application for a certificate of public advantage, the authority shall grant or deny the application. When considered appropriate by the department, the authority may hold a public hearing within such 90 day period.

"NEW SECTION. Section 15. Reconsideration and appeal. (1) Applicants for a certificate of public advantage may request the authority to reconsider its decision. The authority shall grant the request if an applicant submits the request in writing and if the request is received by the authority within 30 calendar days after the initial decision is announced.

(2) A public hearing to reconsider must be held within 30 calendar days after the request is received unless the applicants agree to waive the time limit.

(3) The reconsideration hearing must be conducted pursuant to the provisions for informal proceedings of the Montana Administrative Procedure Act.

(4) The authority shall make its final decision and serve the applicants with written findings of fact and conclusions of law in support of the decision within 30 days after the conclusion of the reconsideration hearing.

(5) The applicants may appeal the authority's final decision to the district court as provided in Title 2, chapter 4, part 7.

(6) The department may by rule prescribe in greater detail the hearing and appellate procedures.

"NEW SECTION. Section 16. Standards for certification. The authority shall issue a certificate of public advantage for a cooperative agreement if it determines the applicants have demonstrated that the agreement is likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

"NEW SECTION. Section 17. Revocations of certificate of public advantage.(1) The authority may revoke a certificate of public advantage if it determines that the agreement is not resulting in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

(2) A certificate of public advantage may not be revoked without notice and an opportunity for hearing before the authority given as follows:

(a) Written notice shall be given the parties to the cooperative agreement for which the certificate of public advantage is proposed to be revoked not less than 120 days prior to the proposed revocation.

(b) If a party to the cooperative agreement submits a request for hearing in writing and the request is received by the authority within 30 calendar days after notice is mailed to the parties, the authority shall hold a public hearing to determine whether the certificate of public advantage should be revoked.

(c) A public hearing to determine whether the certificate of public advantage should be revoked must be held within 30 calendar days after the request is received.

(d) The hearing must be conducted pursuant to the provisions for informal proceedings of the Montana Administrative Procedure Act.

(e) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of the decision within 30 days after the conclusion of the reconsideration hearing.

(f) Any party to the cooperative agreement may appeal the authority's final decision to the district court as provided in Title 2, chapter 5, part 7. No revocation of a certificate of public advantage may become final until the time for appeal to the district court has expired.

(g) If a petition to appeal the revocation of a certificate of public advantage is filed, the revocation must be stayed pending resolution of the appeal by the courts.

(h) The authority may by rule prescribe in greater detail the hearing and appellate procedures.

(3) The authority may by rule establish reporting requirements for parties to a cooperative agreement for which a certificate of public advantage is in effect for the purpose of determining whether the agreement continues to be likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

"NEW SECTION. Section 18. Recordkeeping. The authority shall maintain on file cooperative agreements for which a certificate of public advantage is in effect. Any party to a cooperative agreement who terminates the agreement shall file written notice of the termination within 30 days after such termination.

Renumber: subsequent sections.

6. Page 22.

Following: "[Section 13(1) through (9)]"

Delete: "is"

Insert: "and [Sections 13 through 18] are"

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BILL NO. 285

INTRODUCED BY

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL

HEALTH CARE ACCESS, HEALTH CARE PLANNING AND COST

CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;

PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;

REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;

REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING

FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;

REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON

LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH

PLANNING REGIONS AND BOARDS; PROVIDING FOR THE POWERS AND

DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A

UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH

INSURANCE REFORM; TRANSFERRING TO THE AUTHORITY CERTAIN

FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND

ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS;

AMENDING SECTION 50-15-101, MCA; AND PROVIDING EFFECTIVE

DATES."

STATEMENT OF INTENT

A statement of legislative intent is required for this bill because [section 13] requires the Montana health care authority to adopt rules establishing a maximum of five

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7

DATE

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 MONTANA LEGISLATIVE COUNCIL

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1 health care planning regions, to establish regional health
2 care planning boards within those regions, and to establish
3 a procedure for selection of regional board members. The
4 ~~legislature intends that the rules establishing the health~~
5 ~~care planning regions be based primarily upon the geographic~~
6 ~~health care referral patterns by which health care providers~~
7 ~~refer patients to specialists or larger health care~~
8 ~~facilities. These rules should also consider communication~~
9 ~~and transportation patterns and natural barriers to these~~
10 ~~patterns.~~ The rules establishing the boards must specify the
11 number of members, any relevant qualifications, and the
12 operations and duties of the boards and must provide for a
13 funding mechanism by grant from the authority. The procedure
14 for selection of the board members must provide for public
15 notice of the selection process.

16 A statement of intent is also required because [section
17 15] requires the authority to adopt rules relating to the
18 unified health care data base. The authority's rules must
19 specify in comprehensive detail what information is required
20 to be provided by health care providers and the times at
21 which the information is to be provided. The rules must also
22 provide for audit procedures to determine the accuracy of
23 the filed data. The confidentiality provisions must be
24 consistent with other state laws governing the
25 confidentiality of public records, including medical

1 records, and must apply to employees of the authority and to
2 others receiving or using records in the data base.

3 A statement of intent is also required because [section
4 17] requires the commissioner of insurance to adopt rules
5 governing small employer group health plans. In determining
6 the basic benefits package, the commissioner shall make
7 objective determinations, supported by available data,
8 concerning the type of benefits required and shall determine
9 that the benefits to be required are cost-effective.

14

15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

16 NEW SECTION. Section 1. State health care policy. (1)

17 It is the policy of the state of Montana to ensure that all
18 residents have access to quality health services at costs
19 that are affordable. To achieve this policy, it is necessary
20 to develop a health care system that is integrated and
21 subject to the direction and oversight of a single state
22 agency. Comprehensive health planning through the
23 application of a statewide health resource management plan
24 that is linked to a unified health care budget for Montana
25 is essential.

1 (2) It is further the policy of the state of Montana
2 that the health care system should:

3 (a) maintain and improve the quality of health care
4 services offered to Montanans;

5 (b) contain or reduce increases in the cost of
6 delivering services so that health care costs do not consume
7 a disproportionate share of Montanans' income or the money
8 available for other services required to ensure the health,
9 safety, and welfare of Montanans;

10 (c) avoid unnecessary duplication in the development
11 and offering of health care facilities and services;

12 (d) encourage regional and local participation in
13 decisions about health care delivery, financing, and
14 provider supply;

15 (e) promote rational allocation of health care
16 resources in the state; and

17 (f) facilitate universal access to preventive and
18 medically necessary health care.

5 of [sections 2 through 13], the following definitions apply:

6 (1) "Authority" means the Montana health care authority
7 created by [section 1].

8 (2) "Board" means one of the regional health care
9 planning boards created pursuant to [section 10].

10 (3) "Data base" means the unified health care data base
11 created pursuant to [section 12].

12 (4) "Health care facility" means all facilities and
13 institutions, whether public or private, proprietary or
14 nonprofit, that offer diagnosis, treatment, and inpatient or
15 ambulatory care to two or more unrelated persons. The term
16 includes all facilities and institutions included in
17 50-5-101(19). The term does not apply to a facility operated
18 by religious groups relying solely on spiritual means,
19 through prayer, for healing.

20 (5) "Health insurer" means any health insurance
21 company, health maintenance organization, insurer providing
22 disability insurance as described in 33-1-207, and, to the
23 extent permitted under federal law, any administrator of an
24 insured, self-insured, or publicly funded health care
25 benefit plan offered by public and private entities.

1 (6) "Health care provider" or "provider" means a person
2 who is licensed, certified, or otherwise authorized by the
3 laws of this state to provide health care in the ordinary
4 course of business or practice of a profession.

5 (7) "Management plan" means the health care resource
6 management plan required by [section 6].

7 (8) "Region" means one of the health care planning
8 regions created pursuant to [section 10].

9 (9) "Statewide plan" means one of the statewide
10 universal health care access plans for access to health care
11 required by [section 4].

12 NEW SECTION. Section 3. Montana health care authority

13 -- allocation -- ~~membership~~. (1) There is a Montana health
14 care authority.

15 (2) The authority is allocated to the department of
16 health and environmental sciences for administrative
17 purposes as provided in 2-15-121.

18 (3) The authority consists of five voting members

Each member

- 2 must be knowledgeable in different aspects of health care.
- 3 Three members must be health care consumers or represent
- 4 consumer organizations.

20 (a) Within 30 days of [the effective date of this
21 section], the majority and minority leader of the house of
22 representatives shall select an individual with recognized
23 expertise or interest, or both, in health care. The majority
24 and minority leader and the person selected by them shall
25 nominate by majority vote five individuals for appointment

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1 to the authority.

2 (b) Within 30 days of [the effective date of this
3 section], the majority and minority leader of the senate
4 shall select an individual with recognized expertise or
5 interest, or both, in health care. The majority and minority
6 leader and the person selected by them shall nominate by
7 majority vote five individuals for appointment to the
8 authority.

9 (c) Within 90 days of [the effective date of this
10 section], the governor shall appoint from those nominated
11 under subsections (3)(a) and (3)(b) five individuals to the
12 authority.

13 (4) A vacancy must be filled in the same manner as
14 original appointments under subsection (3), except that one
15 individual must be selected under subsection (3)(a) and one
16 under subsection (3)(b). The governor shall appoint from
17 those nominated the individual to fill the vacancy.

18 (5) The presiding officer of the authority must be
19 elected by majority vote of the voting members. The initial
20 presiding officer must serve a 4-year term.

21 (6) Members serve terms of 4 years, except that of the
22 members initially appointed, two members serve 4-year terms,
23 two members serve 3-year terms, and one member serves a
24 2-year term, to be determined by lot.

25 (7) The directors of the department of social and
1 rehabilitation services and the department of health and
2 environmental sciences are nonvoting, ex-officio members of
3 the authority.

3 (5) The authority shall report to the legislature and
4 the governor at least twice a year on its progress since the
5 last report in fulfilling the requirements of [sections 2
6 through 13]. Reports may be provided in a manner similar to
7 5-11-210 or in another manner determined by the authority.

14 (6) All the board members must be full-time state
15 employees, exempt from Title 2, chapter 18, parts 1 and 2.
16 The annual salary of the presiding officer is 85% of the
17 annual salary of the presiding officer of the public service
18 commission. The annual salary of each of the other members
19 is 85% of the annual salary of public service commissioners
20 other than the presiding officer.

10 (7) The authority shall make grants to the boards for
11 the operation of the boards. The authority shall provide for
12 uniform procedures for grant applications and budgets of the
13 boards.

14 NEW SECTION. Section 5. Statewide universal health
15 care access plans required. On or before October 1, 1994,
16 the authority shall submit a report to the legislature that
17 contains the authority's recommendation for a statewide
18 universal health care access plan based on a single payor
19 concept and a recommendation for a statewide universal
20 access plan based on a regulated multiple payor concept.
21 Each statewide plan must guarantee access to health care
22 services for residents of Montana by making available a
23 uniform system of health care benefits. Each statewide plan
24 must contain the features required by this section and
25 [sections 5 through 8].

12

13

14 . (2) On or before
15 November 1, 1994, the board shall submit a report to the
16 legislature containing the board's recommendations,
17 including any necessary legislation, for a universal access
18 plan based on the concept of a single payor. The plan must
19 contain recommendations that if implemented, would provide
20 universally accessible, medically necessary, and preventive
21 health care by October 1, 1995.

22 (3) For the purposes of this section, "single payor
23 system" means a method of financing health services
24 predominantly through public funds so that all residents of
25 Montana would have available to them a uniform set of
benefits established by statute or administrative rule.

1 Policies governing all aspects of the management of the
2 single payor system reside with state government, and
3 benefits would be administered by a single entity. The
4 single payor system must include:

5 (a) universal coverage for all Montana residents;

6 (b) a single governmental or nongovernmental
7 administrative entity that makes payments through contracts
8 with health care providers;

9 (c) portability of coverage regardless of job status;

10 (d) uniform benefits from a single source for all
11 Montana residents;

12 (e) a broad-based public financing mechanism, including
13 revenues from employers, employees, public sources, or any
14 combination of the listed sources;

15 (f) a system capped for provider expenditures;

16 (g) global budgeting for hospitals;

17 (h) controlled capital expenditures;

18 (i) a binding cap on overall expenditures; and

19 (j) policymaking for the system as a whole and
20 accountability within state government.

21 (4) The single payor system must provide for the use of
22 the state health resource management plan, the unified
23 health care budget, , the
24 certificate of need process, and other health care cost
25 containment mechanisms. The single payor system must include

1 the following features:

2 (a) an integrated system or systems of health care
3 delivery;

4 (b) incentives to be used to contain costs and direct
5 resources;

6 (c) uniform benefits to be made available, including
7 nutrition benefits, prenatal benefits, and maternity care;

8 (d) reimbursement mechanisms for health care providers;

9 (e) administrative efficiencies;

10 (f) the appropriate use of midlevel practitioners, such
11 as physicians' assistants and nurse practitioners;

12 (g) mechanisms for applying and implementing the
13 unified health care budget on a statewide basis to all
14 sectors of the health care system;

15 (h) mechanisms for reducing the cost of prescription
16 drugs, both as part of and as separate from the uniform
17 benefit plan;

18 (i) appropriate reallocation of existing health care
19 resources;

20 (j) equitable financing of the proposal;

21 (k) requirements for the payment of premiums or
22 copayments by health care consumers, based upon family size
23 and ability to pay;

24 (l) a waiting period of a total of 3 months prior to
25 receipt of benefits for a person who has been a resident of

1 Montana for less than that period of time; and

2 (4) integration, to the extent possible under federal
3 and state law, of benefits provided under the single payor
4 system with the benefits provided by the United States
5 department of veterans affairs and benefits provided by the
6 Indian health service.

7 (5) The single payor system must also include a
8 mechanism for the authority to provide health care in those
9 areas of Montana near the borders where it would be more
10 practicable for health care consumers to seek care from
11 metropolitan areas in neighboring states. If the authority
12 determines that contracts with out-of-state providers are
13 required to provide this mechanism and that it lacks
14 sufficient authority to contract with those providers, the
15 authority shall in its report propose legislation necessary
16 for the exercise of those powers.

17 (6) In its report, the authority shall present, at a
18 minimum, the range of services that would be available under
19 the universal access plan if there were no increase, beyond
20 inflation, in the total gross health care expenditures in
21 Montana, as determined by the authority from the health care
22 data base established under [section 12] for the first year
23 that an expenditure figure is available.

24 (7) In developing the universal access plan, the
25 authority shall examine the effect of government regulation

1 and economic incentives on the overall operation of the
2 health care system and, specifically, on how those parts of
3 the universal access plan recommended pursuant to
4 subsections (2) through (5) may most appropriately be used
5 in furthering the policies and goals of [sections 1, 2, and
6 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4;
7 Title 90, chapter 7; and [section 37].

8 (8) Hearings on universal access
9 plan. The board shall seek public comment on the development
10 of the universal access plan. In seeking public comment on
11 the development of the board's recommendations for the
12 universal access plan, the board shall provide extensive,
13 multimedia notice to the public and hold at least one public
14 hearing in each of the health care planning regions
15 established by [section 27]. To the extent possible, the
16 board shall arrange for hearings to be broadcast on
17 interactive television. The hearings must take place before
18 the board's report is submitted to the legislature. The
19 board shall consult with health care providers in the
20 development of the board's recommendations for the universal
21 access plan.

21 Process. (9) The board shall conduct a study of the
22 certificate of need process established under Title 50,
23 chapter 5, part 3. The study must determine whether changes
24 in the certificate of need process are necessary or
25 desirable in light of the board's recommendation for a
1 single payor health care system required by [section 17].
2 The study must include consideration of the role, effect,
3 and desirability of:

- 4 (a) maintaining the exemptions from the certificate of
5 need process for offices of private physicians, dentists,
6 and other physical and mental health care professionals; and
7 (b) maintaining the dollar thresholds for health care
8 services, equipment, and buildings and for construction of
9 health care facilities.

10 (2) The results of the study, including any
11 recommendations for legislation and changes in an agency's
12 policies or rules, must be reported to the legislature no
13 later than December 1, 1994.

NEW SECTION. Section 6. Cost containment. (1) The

statewide plans must contain a cost containment component. Except as otherwise provided in this section, each statewide plan must establish a target for cost containment so that by 1999, the annual average percentage increase in statewide health care costs does not exceed the average annual percentage increase in the gross domestic product, as determined by the U.S. department of commerce, for the 5 preceding years.

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(2) The health care expenditure target may include

sectors or subsectors for health care facilities, health care providers, or any other part of the health care system that the board determines is necessary. The board shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the expenditure target. Prior to adopting the expenditure target, the board shall adopt:

(a) the methods and processes to be used to allocate resources among sectors; and

(b) the economic indicators to be used to define the parameters of the rate of growth in the cost of the system and the various sectors of the system.

(3) The authority shall include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the

1 same rate for the same health care services and items and
2 that reimbursement for services is based predominantly upon
3 the health care service provided rather than upon the
4 discipline of the health care provider.

5 (d) a method of monitoring compliance with the target
6 required in subsection (1);

7 (e) expenditure targets for health care providers and facilities

8 (f) disincentives for exceeding the targets established
9 pursuant to subsection (3)(e), including reduction of
10 reimbursement levels in subsequent years;

11 (g) reimbursement of health care providers and health
12 care facilities that is based upon negotiated annual budgets
13 or fees for services; and

14 (h) a plan by the authority, health care providers, and
15 health care facilities to educate the public concerning the
16 purpose and content of the statewide plans.

10 (8) The board shall enter into discussions or
11 nonbinding negotiations with health care facilities and any
12 health care provider bargaining groups created under
13 [section 11] concerning matters related to the sectors of
14 the unified health care budget.

17 NEW SECTION. Section 7. Health care resource
18 management plan. (1) Each statewide plan must contain a
19 health care resource management plan. The management plan
20 must provide for the distribution of health care resources
21 within the regions established pursuant to [section 10] and
22 within the state as a whole, consistent with the principles
23 provided in subsection (2).

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- 5 (c) the state plan must include:
- 6 (a) a statement of principles used in the allocation of
7 resources and in establishing priorities for health
8 services;
- 9 (b) identification of the current supply and
10 distribution of:
- 11 (i) hospital, nursing home, and other inpatient
12 services;
- 13 (ii) home health and mental health services;
- 14 (iii) treatment services for alcohol and drug abuse;
- 15 (iv) emergency care;
- 16 (v) ambulatory care services, including primary care
17 resources;
- 18 (vi) nutrition benefits, prenatal benefits, and
19 maternity care;
- 20 (vii) human resources;
- 21 (viii) major medical equipment; and
- 22 (ix) health screening and early intervention services;
- 23 (c) a determination of the appropriate supply and
24 distribution of the resources and services identified in
25 subsection (b)(i) and of the mechanisms that will encourage
1 the appropriate integration of these services on a local or
2 regional basis. To arrive at a determination, the authority
3 shall consider the following factors:
- 4 (i) the needs of the statewide population, with special
5 consideration given to the development of health care
6 services in underserved areas of the state;
- 7 (ii) the needs of particular geographic areas of the
8 state;
- 9 (iii) the use of Montana facilities by out-of-state
10 residents;
- 11 (iv) the use of out-of-state facilities by Montana
12 residents;
- 13 (v) the needs of populations with special health care
14 needs;
- 15 (vi) the desirability of providing high-quality services
16 in an economical and efficient manner, including the
17 appropriate use of midlevel practitioners; and
- 18 (vii) the cost impact of these resource requirements on
19 health care expenditures.
- 20 (d) a component that addresses health promotion and
21 disease prevention and that is prepared by the department of
22 health and environmental sciences in a format established by
23 the authority; and

(j) include incentives to improve access to and use of preventive care; primary care services, including mental health services; and community-based care;

(ii) include incentives for healthy lifestyles; and

(e) a component that addresses integration of the plan, to the extent allowed by state and federal law, with

services provided by the Indian health service and by the United States department of veterans affairs, and by the Medicaid and Medicare Program

(3) The state plan must be based upon the regional health resource plans prepared by regional panels in accordance with [section 30]. The board shall adopt rules to ensure that regional health resource plans are developed in a consistent manner.

(4) The state plan must be revised annually in a manner determined by the board.

(5) Prior to adoption of the state plan, the board shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the board shall adopt the state plan, taking comments into consideration.

(5) include incentives to improve access to health care in underserved areas, including:

(a) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and

(b) tax credits and other financial incentives to attract and retain health care professionals in underserved areas;

NEW SECTION. Section 8. Health care billing simplification. (1) Each statewide plan must contain a component providing for simplification and reduction of the

1 costs associated with health care billing. In designing this
2 component, the authority may consider:

3 (a) conversion from paper health care claims to
4 standardized electronic billing;

5 (b) creating a claims clearinghouse, consisting of a
6 state agency or private entity, to receive claims from all
7 health care providers for compiling, editing, and submitting
8 the claims to payors; and

4
5 (2) By January 1, 1994, the commissioner of
6 insurance, after consultation with the board, shall adopt by
7 rule uniform health insurance claim forms and uniform
8 standards and procedures for the use of the forms and
9 processing of claims, including the submission of electronic
10 claim forms.

11 (2) The health care billing component must include a
12 method to educate and assist health care providers and
13 payors who will use any health care billing simplification
14 system recommended by the authority.

15 (3) The billing component must provide a schedule for a
16 phase-in of any health care billing simplification system
17 recommended by the authority. The schedule must relieve
18 health care providers, payors, and consumers of undue
19 burdens in using the system.

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11 NEW SECTION. Section 7. Health care provider
12 bargaining groups. (1) The board may approve the creation of
13 one or more health care provider bargaining groups,
14 consisting of health care providers who choose to
15 participate. On behalf of all of its member providers, a
16 bargaining group is authorized to negotiate:
17 (a) with the authority with respect to any matter
18 authorized by [section 8] related to sectors of the unified
19 health care budget and with respect to any matter related to
20 reimbursement of health care providers; and
21 (b) with the Montana health care purchasing pool, with
22 respect to any matter authorized by [section 8] and to any
23 matter related to reimbursement of health care providers.
24 (2) The board shall adopt by rule:
25 (a) criteria for forming and approving bargaining
1 groups; and
2 (b) criteria and procedures for negotiations authorized
3 by this section.
4 (3) The rules relating to negotiations pertaining to
5 sectors of the unified health care budget must include
6 provisions for a nonbinding arbitration process to assist in
7 the resolution of disputes. This section or rules adopted
8 under this section may not be construed to limit the board's
9 authority to reject the recommendation or decision of the
10 arbiter or limit the board's authority under [section 8] to
11 establish the unified budget.
12 (4) Contracts for reimbursement of health care
13 providers negotiated under this section must be consistent
14 with the unified health care budget and the state health
15 resource management plan and may not take effect unless
16 approved by the board.
17 (5) One or more health care providers may jointly
18 comment on rules proposed by the board and discuss any other
19 matters related to negotiations between the authority and
20 health care providers.
21 (6) The negotiations authorized by this section are
22 limited to the right to discuss the matters identified in
23 subsection (1) and may not be construed to authorize a
24 bargaining group to engage in any other type of activity.
25 The board shall adopt rules to implement this subsection.

20 NEW SECTION. Section 10. Other matters to be included
21 in statewide plans. (1) The statewide plans recommended by
22 the authority must include:

23 (a) stable financing methods, including sharing of the
24 costs of health care by health care consumers on an
25 ability-to-pay basis through such mechanisms as copayments

1 or payment of premiums;

2 (b) a procedure for evaluating the quality of health
3 care services;

4 (c) public education concerning the statewide plans
5 recommended by the authority; and

6 (d) phase in of the various components of the plans.

23 (e) On or before December 15, 1994, and December 15,
24 1996, the board shall report to the legislature on ~~the~~^{an}
25 operation of the purchasing pool, including the number and
1 types of groups and group members participating in the pool,
2 the costs of administering the pool, the savings
3 attributable to participating groups from the operation of
4 the pool, and any changes in legislation considered
5 necessary by the board.

6 (f) On or before December 15, 1996, the board shall
7 report to the legislature with its recommendations
8 concerning the feasibility and merits of authorizing the
9 board to act as an insurer in pooling risks and providing
10 benefits, including a common benefits plan, to participants
11 of the purchasing pool.

7 (2) (a) In order to reduce the costs of defensive
8 medicine, the authority shall:

9 (i) conduct a study of tort reform measures, including
10 limitations on the amount of noneconomic damages, mandated
11 periodic payments of future damages, and reverse sliding
12 scale limits on contingency fees; and

13 (ii) propose any changes, including legislation, that it
14 considers necessary, including measures for compensating
15 victims of tortious injuries.

16 (b) As part of its study, the authority may consider
17 changes in the Montana Medical Legal Panel Act.

18 (c) The recommendations of the authority must be
19 included in its report containing the statewide plans.

20 (3) The
21 legislature finds that the goals of controlling health care
22 costs and improving the quality of and access to health care
23 services will be significantly enhanced by some cooperative
24 arrangements involving health care providers or purchasers
25 that would be prohibited by state and federal antitrust laws

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1 if undertaken without governmental involvement. The purpose
2 of this section is to create an opportunity for the state to
3 review proposed arrangements and to substitute regulation
4 for competition when an arrangement is likely to result
5 either in lower costs or in greater access or quality than
6 would otherwise occur in the competitive marketplace. The
7 legislature intends that approval of relationships be
8 accompanied by appropriate conditions, supervision, and
9 regulation to protect against private abuses of economic
10 power.

11 (4) The authority shall establish criteria and
12 procedures to review and authorize contracts, business or
13 financial arrangements, or other activities, practices, or
14 arrangements involving providers or purchasers that might be
15 construed to be violations of state or federal antitrust
16 laws but that are in the best interests of the state and
17 further the policies and goals of [sections 1, 2, and 5
18 through 30]. The authority may not approve any application
19 unless the authority finds that the proposed arrangement is
20 likely to result in lower health care costs or in greater
21 access to or quality of health care than would occur in the
22 competitive marketplace. The authority may condition
23 approval of a proposed arrangement on a modification of all
24 or part of the arrangement to eliminate any restriction on
25 competition that is not reasonably related to the goals of

1 controlling costs or improving access or quality. The
2 authority may also establish conditions for approval that
3 are reasonably necessary to protect against any abuses of
4 private economic power and to ensure that the arrangement is
5 appropriately supervised and regulated by the state. The
6 authority shall actively monitor and regulate arrangements
7 approved under this section to ensure that the arrangements
8 remain in compliance with the conditions of approval. The
9 authority may revoke an approval upon a finding that the
10 arrangement is not in substantial compliance with the terms
11 of the application or the conditions of approval.

12 (5) (a) Applications for approval under this section
13 must be filed with the authority. An application for
14 approval must describe the proposed arrangement in detail.
15 The application must include:

- 16 (i) the identities of all parties;
- 17 (ii) the intent of the arrangement;
- 18 (iii) the expected effects of the arrangement;
- 19 (iv) an explanation of how the arrangement will control
20 costs or improve access or quality; and
- 21 (v) financial statements showing how the efficiencies
22 of operation will be passed along to patients and purchasers
23 of health care.

24 (b) The authority may ask the attorney general to
25 comment on an application, but the application and any
1 information obtained by the authority under this section are
2 not admissible in any proceeding brought by the attorney
3 general based on antitrust.

4 (6) Notwithstanding the state statutes concerning
5 unfair trade practices, any contracts, business or financial
6 arrangements, or other activities, practices, or
7 arrangements involving providers or purchasers that are
8 approved by the authority under this section do not
9 constitute an unlawful contract, combination, or conspiracy
10 in unreasonable restraint of trade or commerce or unfair
11 trade practices under Title 30, chapter 14. Approval by the
12 authority is an absolute defense against any action under
13 state antitrust or unfair trade practices laws.

14 (7) The authority shall adopt rules to implement this
15 section.

8 (3) The authority shall apply for waivers from federal
9 laws necessary to implement recommendations of the authority
10 enacted by the legislature and to implement those
11 recommendations not requiring legislation.

5 NEW SECTION. Section 11 Study of prescription drug
6 cost and distribution. The authority shall conduct a study
7 of the cost and distribution of prescription drugs in this
8 state. The study must consider the feasibility of various
9 methods of reducing the cost of purchasing and distributing
10 prescription drugs to Montana residents. The study must
11 include the feasibility of establishing a prescription drug
12 purchasing pool for distribution of drugs through
13 pharmacists in this state. The results of the study,
14 including the board's recommendations for any necessary
15 legislation, must be reported to the legislature by December
16 1, 1994. If the board determines that feasible methods are
17 available without need for legislation or further
18 appropriations, the board shall implement that part or those
19 parts of its recommendations.

12 NEW SECTION. Section 12 Long-term care study and
13 ~~recommendations~~. The authority shall conduct a study of the
14 long-term care needs of state residents and report to the
15 public and the legislature the authority's recommendations,
16 including any necessary legislation, for meeting those
17 long-term care needs. The report must be available to the
18 public on or before September 1, 1996, after which the
19 authority shall conduct public hearings on its report in
20 each region established under [section 10]. The authority
21 shall present its report to the legislature on or before
22 January 1, 1997.

15 (2) This section does not preclude the authority from
16 recommending cost-sharing arrangements for long-term care
17 services or from recommending that the services be phased in
18 over time. The board's recommendations must support and may
19 not supplant informal care giving by family and friends and
20 must include cost containment recommendations for any
21 long-term care service suggested for inclusion.

22 (3) The board's report must estimate costs associated
23 with each of the long-term care services recommended and may
24 suggest independent financing mechanisms for those services.
25 The report must also set forth the projected cost to Montana
1 and its citizens over the next 20 years if there were no
2 change in the present accessibility, affordability, or
3 financing of long-term care services in this state.

4 (4) The board shall consult with the department of
5 social and rehabilitation services in developing its
6 recommendations under this section.

- 22a -

NEW SECTION. Section 13. Health care planning regions. (1) There are five health care planning regions. Subject to subsection 2, the regions consists of the following counties:

(a) Region I: Daniels, Sheridan, Roosevelt, McCone, Richland, Dawson, Wibaux, Prairie, Custer, Fallon, Powder River, and Carter;

(b) Region II: Glacier, Tool, Liberty, Hill, Blaine, Pondera, Chouteau, Teton, Cascade, Judith Basin, and Fergus;

(c) Region III: Phillips, Valley, Garfield, Rosebud, Treasurer, Petroleum, Musselshell, Golden Valley, Stillwater, Yellowstone, Big Horn, and Carbon;

(d) Region IV: Wheatland, Sweetgrass, Park, Meagher, Broadwater, Callatin, Madison, Beaverhead, Silver Bow, Deer Lodge, Jefferson, and Lewis and Clark;

(e) Region V: Powell, Granite, Ravalli, Missoula, Mineral, Sanders, Lake, Flathead, and Lincoln;

8 (2) (a) A county may, by written request of the board
9 of county commissioners, petition the authority at any time
10 to be removed from a health care planning region and added
11 to another region.

12 (b) The authority shall grant or deny the petition
13 after a public hearing upon notice as the authority
14 determines. The authority shall grant the petition if it
15 appears by a preponderance of the evidence that the
16 petitioning county's health care interests are more strongly
17 associated with the region that the county seeks to join
18 than with the region in which the county is then located. If
19 the authority grants the petition, the county is considered
20 for all purposes to be part of the health care planning
21 region as approved by the board.

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(3) Within each health care planning region created by [section 27] is a regional health care planning panel.

(4) Each regional panel consists of 11 members as provided in this section. Regional panel members must be appointed for 6-year terms, except that of the first panels appointed, three members must be appointed for a term of 2 years, three members must be appointed for a term of 4 years, and five members must be appointed for a term of 6 years.

(5) The county commission of each county within a region shall nominate five persons for membership on the regional panel. The list of nominees must be sent to the authority, which shall select from the list of nominees the members on each regional panel.

(6) Each regional panel must include:

(a) at least five members who represent health care consumers and who are not affiliated with a health care profession or health care facility;

(b) at least two representatives of health care providers;

(c) at least one representative of hospitals;

(d) at least one representative of health care facilities; and

(e) at least two representatives of private business.

(7) Each regional panel must include experts in law, economics, and other fields and must include members of the health care professions, sufficient for the panel to carry out its duties under [section 30].

(8) Within each region, the board shall establish by rule a regional health care planning board. Each board must include one member from each county within their respective regions. The members on each board must represent a balance of individual who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care.

13 (9) The authority shall, within 30 days of appointment
14 of its members, propose by rule a procedure for selecting
15 members of boards. The authority shall select five members
16 for each board within 180 days of appointment of the
17 authority, using the selection procedure adopted by rule
18 under this subsection. Vacancies on a board must be filled
19 by using the authority's selection process.

20 (10) Regional board members serve 4-year terms, except
21 that of the board members initially selected, one member
22 serves for 2 years, two members serve for 3 years, and two
23 members serve for 4 years, to be determined by lot. A
24 majority of each regional board shall select a presiding
25 officer. The presiding officer initially selected must serve
1 a 1-year term. Board members must be compensated and
2 reimbursed in accordance with 2-15-124.

3 NEW SECTION. Section 14 Duties of boards. A board
4 shall:

5 (1) meet at the time and place designated by the
6 presiding officer, but not less than quarterly;

7 (2) submit an annual budget and grant application to
8 the authority at the time and in the manner directed by the
9 authority;

10 (3) adopt procedures governing its meetings and other
11 aspects of its day-to-day operations as the board determines

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13 (4) develop regional health resource plans that must
14 address the health care needs of the region, address the
15 development of health care services in underserved areas of
16 the region and other matters, and be in the format
17 determined by the authority;

18 (5) revise the regional plan annually;

19 (6) hold at least one public hearing on the regional
20 plan within the region at the time and in the manner
21 determined by the regional panel;

22 (7) transmit the regional plan to the authority at the
23 time determined by the authority;

24 (8) apply to the authority for grant funds for
25 operation of the regional panel and account, in the manner
1 specified by the authority, for grant funds provided by the
2 authority; and

3 (9) seek from local sources money to supplement grant
4 funds provided by the authority.

5 (10) regional boards may:

6 (11) recommend that the authority sanction voluntary
7 agreements between health care providers and between health
8 care consumers in the region that will improve the quality
9 of, access to, or affordability of health care but that
10 might constitute a violation of antitrust laws if undertaken
11 without government direction;

12 (12) make recommendations to the authority regarding
13 major capital expenditures or the introduction of expensive
14 new technologies and medical practices that are being
15 proposed or considered by health care providers;

16 (13) undertake voluntary activities to educate
17 consumers, providers, and purchasers and promote voluntary,
18 cooperative community cost containment, access, or quality
19 of care projects; and

20 (14) make recommendations to the department of health
21 and environmental sciences or to the authority, or both,
22 regarding ways of improving affordability, accessibility,
23 and quality of health care in the region and throughout the
24 state.

25 (15) Each regional board may review and advise the
1 authority on regional technical matters relating to the
2 universal access plan required by [section 17], the common
3 benefits package, procedures for developing and applying
4 practice guidelines for use in the universal access plan,
5 provider and facility contracts with the state, utilization
6 review recommendations, expenditure targets, and uniform
7 health care benefits and their impact upon the provision of
8 quality health care within the region.

NEW SECTION. Section 17. Health care data base --

information submitted -- enforcement. (1) The authority shall develop and maintain a unified health care data base that enables the authority, on a statewide basis, to:

(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;

(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and cost-effective health care;

(c) conduct evaluations of health care procedures and health care protocols; and

(d) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities.

(2) The authority shall by rule require health care providers, health insurers, and health care facilities, private entities, and entities of state and local governments to file with the authority the reports, data, schedules, statistics and other information determined by the authority to be necessary to fulfill the purposes of the data base provided in subsection (1). Material to be filed

1 with the authority may include health insurance claims and
2 enrollment information used by health insurers.

3 (3) The authority may issue subpoenas for the
4 production of information required under this section and
5 may issue subpoenas for and administer oaths to any person.
6 Noncompliance with a subpoena issued by the authority is,
7 upon application by the authority, punishable by a district
8 court as contempt pursuant to Title 3, chapter 1, part 5.

9 (4) The data base must:

10 (a) use unique patient and provider identifiers and a
11 uniform coding system identifying health care services; and

12 (b) reflect all health care utilization, costs, and
13 resources in the state and the health care utilization and
14 costs of services provided to Montana residents in another
15 state.

16 (5) Information in the data base required by law to be
17 kept confidential must be maintained in a manner that does
18 not disclose the identity of the person to whom the
19 information applies.

20 (6) The authority shall adopt by rule a confidentiality
21 code to ensure that information in the data base is
22 maintained and used according to state law governing
23 confidential health care information.

24 (7) The duties of the authority under this section may
25 not be construed to allow the authority to use the data base

1 to manage a health care facility in a manner that
2 usurps the appropriate powers of the board of directors of
3 the facility.

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15 NEW SECTION. Section 16 Health insurer cost management
16 plans. (1) (a) Except as provided in subsection (3), each
17 health insurer shall:

18 (i) prepare a cost management plan that includes
19 integrated systems for health care delivery; and

20 (ii) file the plan with the board no later than January
21 1, 1994.

22 (b) The board may use plans filed under this section in
23 the development of the unified health care budget.

24 (2) The plans required by this section must be
25 developed in accordance with standards and procedures

1 established by the board.

2 (3) The provisions of this section do not apply to
3 dental insurance.

4 NEW SECTION. Section 17. Small employer group health
5 insurance reform. (1) As used in this section, the following
6 definitions apply:

7 (a) "Health plan" or "plan" means the plan specified in
8 the rules adopted pursuant to subsection (2).

9 (b) "Person" means an individual, corporation, firm,
10 partnership, sole proprietorship, or other business entity.

11 (c) "Small employer" means a person employing at least
12 3 but not more than 25 employees.

13 (2) The commissioner of insurance shall adopt rules
14 specifying the health care benefits to be included in health
15 care plans offered by small employers.

16 (3) A health insurer who offers a health plan to a
17 small employer in Montana shall offer the same health plan
18 to other small employers in Montana and shall allow
19 continuous open enrollment in that plan.

20 (4) A health insurer who offers a health plan may not
21 limit preexisting conditions for a period longer than 6
22 months after the effective date of coverage under the plan.

23 (5) A health insurer may not cancel, refuse to issue,
24 or refuse to renew coverage under a health plan for any

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1 material misrepresentation by the insured in the application
2 for coverage under the plan.

3 (6) A health insurer shall provide notice to an insured
4 of the terms of renewal of coverage under a health plan at
5 least 10 days before the expiration of the coverage. The
6 terms upon which coverage under the plan is offered to the
7 insured for renewal may not be any less favorable, with
8 respect to all provisions, including benefits but excluding
9 premium rates and minor administrative changes, than the
10 terms of the coverage about to expire.

11 (7) A health insurer may not charge a higher premium
12 for renewal of coverage under a health plan than for initial
13 coverage under the same plan.

14 (8) A health insurer shall renew coverage under a
15 health plan for not less than 12 months.

16 (9) A health insurer may not require an insured or a
17 person applying for coverage under a health plan with that
18 insurer to comply with limitations in a health plan
19 concerning preexisting conditions if that insured or person
20 has previously satisfied preexisting condition requirements
21 of another health insurance policy or plan offering
22 substantially similar benefits.

23 (10) Except as provided in subsection (11), all health
24 insurers shall establish a single rating scheme that is
25 applied consistently for health plans and does not

discriminate between persons as to the amount of the premium based upon differences in sex, health status, employment, or geographic location.

(11) (a) The commissioner of insurance shall adopt by rule standards and a procedure to allow health insurers to use one or more risk classifications in establishing their rating system. The rating system may not contain a rate spread greater than 30% of the median rate or less than 30% of the median rate.

(b) The commissioner shall phase in the requirements of subsection (10) and this subsection as the commissioner considers appropriate.

(c) By July 1, 1995, a premium rate may not exceed 125% of the premium rate for the least expensive group.

(12) On [6 months from the effective date of this subsection] the commissioner of insurance shall adopt rules implementing this section. The rules adopted by the commissioner become effective on [1 year from the effective date of this subsection].

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9 Section / ~~5~~ Section 50-1-201, MCA, is amended to read:
10 "50-1-201. Administration of state health plan. The
11 department Montana health care authority created in [section
12 31] ~~is hereby established as the sole--and--official~~ state
13 agency to administer the state program for comprehensive
14 health planning and ~~is hereby authorized to~~ shall prepare a
15 plan for comprehensive state health planning. The department
16 ~~authority is authorized to~~ may confer and cooperate with any
17 ~~and--all~~ other persons, organizations, or governmental
18 agencies that have an interest in public health problems and
19 needs. The department authority, while acting in this
20 capacity as the ~~sole-and-official~~ state agency to administer
21 and supervise the administration of the official
22 comprehensive state health plan, is designated and
23 authorized as the ~~sole-and-official~~ state agency to accept,

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1 or appropriated to it for the preparation, and
2 administration, and the supervision of the preparation and
3 administration of the comprehensive state health plan."

4 **Section 19.** Section 50-5-101, MCA, is amended to read:

5 "50-5-101. Definitions. As used in parts 1 through 4 of
6 this chapter, unless the context clearly indicates
7 otherwise, the following definitions apply:

8 (1) "Accreditation" means a designation of approval.

9 (2) "Adult day-care center" means a facility,
10 freestanding or connected to another health care facility,
11 which provides adults, on an intermittent basis, with the
12 care necessary to meet the needs of daily living.

13 (3) "Affected person" means an applicant for
14 certificate of need, a member of the public who will be
15 served by the proposal, a health care facility located in
16 the geographic area affected by the application, an agency
17 which establishes rates for health care facilities, a
18 third-party payer payor who reimburses health care
19 facilities in the area affected by the proposal, or an
20 agency which plans or assists in planning for such affected
21 facilities.

22 (4) "Ambulatory surgical facility" means a facility,
23 not part of a hospital, which provides surgical treatment to
24 patients not requiring hospitalization. This type of
25 facility may include observation beds for patient recovery

1 from surgery or other treatment.

2 (5) "Authority" means the Montana health care authority
3 created by [section 3].

4 (5)(5) "Batch" means those letters of intent to seek
5 approval for new beds or major medical equipment that are
6 accumulated during a single batching period.

7 (6)(7) "Batching period" means a period, not exceeding
8 1 month, established by department authority rule during
9 which letters of intent to seek approval for new beds or
10 major medical equipment are accumulated pending further
11 processing of all letters of intent within the batch.

12 (7)(8) "Board" means the board of health and
13 environmental sciences, provided for in 2-15-2104.

14 (8)(9) "Capital expenditure" means:

15 (a) an expenditure made by or on behalf of a health
16 care facility that, under generally accepted accounting
17 principles, is not properly chargeable as an expense of
18 operation and maintenance; or

19 (b) a lease, donation, or comparable arrangement that
20 would be a capital expenditure if money or any other
21 property of value had changed hands.

22 (9)(10) "Certificate of need" means a written
23 authorization by the department authority for a person to
24 proceed with a proposal subject to 50-5-301.

25 (10)(11) "Challenge period" means a period, not

1 exceeding 1 month, established by department authority rule
2 during which any person may apply for comparative review
3 with an applicant whose letter of intent has been received
4 during the preceding batching period.

5 †††(12) "Chemical dependency facility" means a facility
6 whose function is the treatment, rehabilitation, and
7 prevention of the use of any chemical substance, including
8 alcohol, which that creates behavioral or health problems
9 and endangers the health, interpersonal relationships, or
10 economic function of an individual or the public health,
11 welfare, or safety.

12 †††(13) "Clinical laboratory" means a facility for the
13 microbiological, serological, chemical, hematological,
14 radiobioassay, cytological, immuno-hematological,
15 pathological, or other examination of materials derived from
16 the human body for the purpose of providing information for
17 the diagnosis, prevention, or treatment of any disease or
18 assessment of a medical condition.

19 †††(14) "College of American pathologists" means the
20 organization nationally recognized by that name with
21 headquarters in Traverse City, Michigan, that surveys
22 clinical laboratories upon their requests and accredits
23 clinical laboratories that it finds meet its standards and
24 requirements.

25 †††(15) "Comparative review" means a joint review of

1 two or more certificate of need applications which that are
2 determined by the department authority to be competitive in
3 that the granting of a certificate of need to one of the
4 applicants would substantially prejudice the department's
5 authority's review of the other applications.

6 ~~†15†~~(16) "Construction" means the physical erection of a
7 health care facility and any stage thereof of erection,
8 including ground breaking, or remodeling, replacement, or
9 renovation of an existing health care facility.

10 ~~†16†~~(17) "Department" means the department of health and
11 environmental sciences provided for in Title 2, chapter 15,
12 part 21.

13 ~~†17†~~(18) "Federal acts" means federal statutes for the
14 construction of health care facilities.

15 ~~†18†~~(19) "Governmental unit" means the state, a state
16 agency, a county, municipality, or political subdivision of
17 the state, or an agency of a political subdivision.

18 ~~†19†~~(20) "Health care facility" or "facility" means any
19 institution, building, or agency or portion thereof of any
20 agency, private or public, excluding federal facilities,
21 whether organized for profit or not, used, operated, or
22 designed to provide health services, medical treatment, or
23 nursing, rehabilitative, or preventive care to any person or
24 persons. The term does not include offices of private
25 physicians or dentists. The term includes but is not limited

1 to ambulatory surgical facilities, surgical centers, health
2 maintenance organizations, home health agencies, hospices,
3 hospitals, infirmaries, kidney treatment centers, long-term
4 care facilities, medical assistance facilities, mental
5 health centers, outpatient facilities, public health
6 centers, rehabilitation facilities, residential treatment
7 facilities, and adult day-care centers.

8 †20†(21) "Health maintenance organization" means a
9 public or private organization which that provides or
10 arranges for health care services to enrollees on a prepaid
11 or other financial basis, either directly through provider
12 employees or through contractual or other arrangements with
13 a provider or group of providers.

14 †21†(22) "Home health agency" means a public agency or
15 private organization or subdivision thereof--which of an
16 agency or organization that is engaged in providing home
17 health services to individuals in the places where they
18 live. Home health services must include the services of a
19 licensed registered nurse and at least one other therapeutic
20 service and may include additional support services.

21 †22†(23) "Hospice" means a coordinated program of home
22 and inpatient health care that provides or coordinates
23 palliative and supportive care to meet the needs of a
24 terminally ill patient and ~~his~~ the patient's family arising
25 out of physical, psychological, spiritual, social, and

1 economic stresses experienced during the final stages of
2 illness and dying and that includes formal bereavement
3 programs as an essential component.

4 †23†(24) "Hospital" means a facility providing, by or
5 under the supervision of licensed physicians, services for
6 medical diagnosis, treatment, rehabilitation, and care of
7 injured, disabled, or sick persons. Services provided may or
8 may not include obstetrical care, emergency care, or any
9 other service as allowed by state licensing authority. A
10 hospital has an organized medical staff which that is on
11 call and available within 20 minutes, 24 hours per day, 7
12 days per week, and provides 24-hour nursing care by licensed
13 registered nurses. This term includes hospitals specializing
14 in providing health services for psychiatric, mentally
15 retarded, and tubercular patients.

16 †24†(25) "Infirmery" means a facility located in a
17 university, college, government institution, or industry for
18 the treatment of the sick or injured, with the following
19 subdefinitions:

20 (a) an "infirmery--A" provides outpatient and inpatient
21 care;

22 (b) an "infirmery--B" provides outpatient care only.

23 †25†(26) "Joint ~~com~~mission on accreditation of
24 hospitals" means the organization nationally recognized by
25 that name with headquarters in Chicago, Illinois, that

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1 surveys health care facilities upon their requests and
2 grants accreditation status to any health care facility that
3 it finds meets its standards and requirements.

4 ~~4264~~(27) "Kidney treatment center" means a facility
5 which that specializes in treatment of kidney diseases,
6 including freestanding hemodialysis units.

7 ~~4274~~(28) (a) "Long-term care facility" means a facility
8 or part thereof--which of a facility that provides skilled
9 nursing care, intermediate nursing care, or intermediate
10 developmental disability care to a total of two or more
11 persons or personal care to more than four persons who are
12 not related to the owner or administrator by blood or
13 marriage. The term does not include adult foster care
14 licensed under 52-3-303, community homes for the
15 developmentally disabled licensed under 53-20-305, community
16 homes for persons with severe disabilities licensed under
17 52-4-203, youth care facilities licensed under 41-3-1142,
18 hotels, motels, boardinghouses, roominghouses, or similar
19 accommodations providing for transients, students, or
20 persons not requiring institutional health care, or juvenile
21 and adult correctional facilities operating under the
22 authority of the department of corrections and human
23 services.

24 (b) "Skilled nursing care" means the provision of
25 nursing care services, health-related services, and social

1 services under the supervision of a licensed registered
2 nurse on a 24-hour basis.

3 (c) "Intermediate nursing care" means the provision of
4 nursing care services, health-related services, and social
5 services under the supervision of a licensed nurse to
6 patients not requiring 24-hour nursing care.

7 (d) "Intermediate developmental disability care" means
8 the provision of nursing care services, health-related
9 services, and social services for the developmentally
10 disabled, as defined in 53-20-102(4), or persons with
11 related problems.

12 (e) "Personal care" means the provision of services and
13 care ~~which~~ that do not require nursing skills to residents
14 needing ~~some~~ assistance in performing the activities of
15 daily living.

16 ~~†29†~~(29) "Major medical equipment" means a single unit
17 of medical equipment or a single system of components with
18 related functions ~~which~~ that is used to provide medical or
19 other health services and costs a substantial sum of money.

20 ~~†29†~~(30) "Medical assistance facility" means a facility
21 that:

22 (a) provides inpatient care to ill or injured persons
23 prior to their transportation to a hospital or provides
24 inpatient medical care to persons needing that care for a
25 period of no longer than 96 hours; and

1 (b) either is located in a county with fewer than six
2 residents per square mile or is located more than 35 road
3 miles from the nearest hospital.

4 ~~(30)~~ (31) "Mental health center" means a facility
5 providing services for the prevention or diagnosis of mental
6 illness, the care and treatment of mentally ill patients or
7 the rehabilitation of such mentally ill persons, or any
8 combination of these services.

9 ~~(31)~~ (32) "Nonprofit health care facility" means a health
10 care facility owned or operated by one or more nonprofit
11 corporations or associations.

12 ~~(32)~~ (33) "Observation bed" means a bed occupied for not
13 more than 6 hours by a patient recovering from surgery or
14 other treatment.

15 ~~(33)~~ (34) "Offer" means the holding out by a health care
16 facility that it can provide specific health services.

17 ~~(34)~~ (35) "Outpatient facility" means a facility, located
18 in or apart from a hospital, providing, under the direction
19 of a licensed physician, either diagnosis or treatment, or
20 both, to ambulatory patients in need of medical, surgical,
21 or mental care. An outpatient facility may have observation
22 beds.

23 ~~(35)~~ (36) "Patient" means an individual obtaining
24 services, including skilled nursing care, from a health care
25 facility.

1 ~~†36†~~(37) "Person" means any individual, firm,
2 partnership, association, organization, agency, institution,
3 corporation, trust, estate, or governmental unit, whether
4 organized for profit or not.

5 ~~†37†~~(38) "Public health center" means a publicly owned
6 facility providing health services, including laboratories,
7 clinics, and administrative offices.

8 ~~†38†~~(39) "Rehabilitation facility" means a facility
9 ~~which~~ that is operated for the primary purpose of assisting
10 in the rehabilitation of disabled persons by providing
11 comprehensive medical evaluations and services,
12 psychological and social services, or vocational evaluation
13 and training or any combination of these services and in
14 which the major portion of the services is furnished within
15 the facility.

16 ~~†39†~~(40) "Resident" means a person who is in a long-term
17 care facility for intermediate or personal care.

18 ~~†40†~~(41) "Residential psychiatric care" means active
19 psychiatric treatment provided in a residential treatment
20 facility to psychiatrically impaired individuals with
21 persistent patterns of emotional, psychological, or
22 behavioral dysfunction of such severity as to require
23 24-hour supervised care to adequately treat or remedy the
24 individual's condition. Residential psychiatric care must be
25 individualized and designed to achieve the patient's

1 discharge to less restrictive levels of care at the earliest
2 possible time.

3 ~~(41)~~(42) "Residential treatment facility" means a
4 facility operated for the primary purpose of providing
5 residential psychiatric care to persons under 21 years of
6 age.

7 ~~(42)~~(43) "State health plan" means the plan prepared by
8 the department authority to project the need for health care
9 facilities within Montana and--approved--by--the--statewide
10 health-coordinating-council--and-the-governor."

22 NEW SECTION. Section 10 Effective dates. (1)
23 [Sections 1 through 12, 13(10) through (12), 14, 15, and
24 this section] are effective on passage and approval..

25 (2) [Section 13(1) through (9)] is effective [1 year
1 from the date of passage and approval of this act].

2 NEW SECTION. Section 11. Codification instruction. (1)
3 [Section 1] is intended to be codified as an integral part
4 of Title 2, chapter 15, and the provisions of Title 2,
5 chapter 15, apply to [section 1].

6 (2) [Sections 2 through 13] are intended to be codified
7 as an integral part of Title 50, and the provisions of Title
8 50 apply to [sections 2 through 13].

-End-

COMPARISON OF SPECIFIC PROVISIONS OF INSURANCE REFORM LEGISLATION

DATE 2-15-93BILL NO. SB 285CURRENT STATUTEHOUSE BILL 508SENATE BILL 285 (Current)O'KEEFE AMENDMENTSSEN. CHRISTIAENS' BILLS

Availability	No provisions.	Guaranteed issue	Insurers must offer plan to other small employers and must allow "continuous open enrollment"	Guaranteed issue	Guaranteed issue
Group Size	No provisions.	3 - 25	3 - 25	3 - 25	All individual and group policies, regardless of size.
Whole Groups	No provisions.	Cannot exclude eligible employees based on health status or claims experience.	No specific provision.	Cannot exclude eligible employees based on health status or claims experience.	"Coverage" to every individual.
Applicability		Applies to any policy marketed through a small employer and for which the employer pays a portion of the premium or claims federal tax deductions.	No specific provision.	Applies to any policy marketed through a small employer and for which the employer pays a portion of the premium or claims federal tax deductions.	All individual and group policies, regardless of size.
Renewability	Renewal at insurers' discretion after notice.	Guaranteed renewable except "for cause." Carriers exiting the market barred from re-entry for 5 years.	Guaranteed renewable except "for cause." Must renew for at least 12 months.	Guaranteed renewable except "for cause." Carriers exiting the market barred from re-entry for 5 years.	Guaranteed renewable except "for cause." Carriers exiting the market barred from re-entry for 5 years.
Premium Rate Restrictions	No provisions.	Index rate for one class of business may not exceed index rate for any other class by more than 20%. Within a class of business, rates may not vary from the index rate by more than 30%. Once cost containment goal in SB285 is met, within class rates may not vary by more than 20%. Rating disclosure required.	Rates may not vary by more than 30% from the median rate. By July 1995, a rate may not exceed 125% of the least expensive group.	Index rate for one class of business may not exceed index rate for any other class by more than 20%. Within a class of business, rates may not vary from the index rate by more than 25%. Once cost containment goal in SB285 is met, within class rates may not vary by more than 20%. Rating disclosure required.	No variation in premium rate permitted.
Case Characteristics	No provisions in insurance code.	Demographic and other objective characteristics as regulated by commissioner. Claims experience, health status and duration of coverage not considered case characteristics.	Determined by commissioner.	Demographic and other objective characteristics as regulated by commissioner. Claims experience, health status and duration of coverage not considered case characteristics.	None allowed.

	<u>CURRENT STATUTE</u>	<u>HOUSE BILL 508</u>	<u>SENATE BILL 285 (Current)</u>	<u>O'KEEFE AMENDMENTS</u>	<u>SEN CHRISTIAENS' BILLS</u>
Transitional Period		Three years	None.	Three years	None allowed.
Renewal Rates		Trend plus 15% plus changes in case characteristics. Rate variations due to health status or claims experience applied uniformly within and across groups.	No higher than for initial coverage.	Trend plus 15% plus changes in case characteristics. Rate variations due to health status or claims experience applied uniformly within and across groups.	No specific provision.
"Portability" or Continuity	Preexisting condition exclusion limited to 12 months.	Preexisting condition exclusion limited to 12 months. Credit given for qualifying previous coverage if continuous for 1 year up to no more than 30 days prior to submission for new coverage. Late enrollees subject to 18 months. Individual riders prohibited.	Preexisting condition exclusions limited to 6 months. Preexisting condition exclusion prohibited if previously satisfied in plan offering substantially similar benefits.	Preexisting condition exclusion limited to 12 months. Credit given for qualifying previous coverage if continuous for 1 year up to no more than 30 days prior to submission for new coverage. No difference for late enrollees. Individual riders prohibited.	Preexisting condition exclusion limited to 12 months. Credit given for qualifying previous coverage if continuous for 3 months up to no more than 6 months prior to new coverage. Late enrollees not included.
Risk Sharing Mechanism	Montana Comprehensive Health Association plan available to medically uninsurable.	Prospective reinsurance with broad based funding for net losses.	No specific provision.	Prospective reinsurance, no specified funding for net losses.	No specific provision.
Reinsurance Price		For whole groups: 150% of base reinsurance premium rate. For individuals: 500% of base reinsurance premium rate.	No specific provision.	For whole groups: 150% of base reinsurance premium rate. For individuals: 500% of base reinsurance premium rate.	No specific provision.
Carrier Liability		For each employee or dependent \$5000 plus 20% of next \$50,000 for maximum exposure per insured of \$15,000.	No specific provision.	For each employee or dependent \$5000 plus 20% of next \$100,000 for maximum exposure per insured of \$15,000.	No specific provision.
Consumer Protection Measures		Standards of fair market conduct. Periodic market evaluation.	No specific provision.	Standards of fair market conduct. Periodic market evaluation.	No specific provision.
Other		Basic and standard benefit plans to be determined by committee appointed by commissioner. State mandated benefits and freedom of choice of practitioner waived.	Commissioner to determine benefits to include in policy.	Basic and standard benefit plans to be determined by committee appointed by commissioner. Freedom of choice of practitioner waived.	

MINUTES

**MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION**

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 17, 1993, at 12:00 p.m.

ROLL CALL

Members Present:

Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: Sen. Tom Towe

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Tom Gomez, Legislative Council
Laura Turman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 366, SB 352, SB 403
Executive Action: SB 118, SB 266, SB 291, SB 285, SB 403,
SB 366, SB 352

EXECUTIVE ACTION ON SB 118

Discussion:

Sen. Franklin went over the amendments from February 15, 1993.
(Exhibit #1)

Motion:

Sen. Franklin moved the amendment.

Discussion:

Sen. Klampe asked if Part 3, Subsection B were going to be changed at all. He asked if there had been discussion about the possibility of levying heavy fines in lieu of trying to keep total secrecy, which may be impossible.

Sen. Christiaens said that this was covered under the Fair Credit Reporting Act, and there is a \$15,000 fine for a person who reveals information that is privileged. Sen. Christiaens said he thought that anyone involved in the insurance industry is aware of this.

Sen. Franklin said the insurance people at the meeting were indicating that was correct.

Sen. Klampe asked Sen. Christiaens if the amendment, as written, were asking too much. Sen. Christiaens said no, it wasn't.

Sen. Franklin said that many of the reviewers are nurses who work in utilization review, and Mary Dalton suggested an amendment to add "psychiatric nurse or psychologist" to Line 16. Sen. Franklin said she thought that was appropriate.

Chairman Eck said Subsection 1 had already been stricken.

Sen. Franklin said the language could be inserted as a new amendment under (Section) 5. She agreed that a technical nurse may not be qualified to evaluate psychiatric records.

Motion:

Sen. Christiaens moved the Committee adopt the revised amendments.

Vote:

The motion carried unanimously.

Motion/Vote:

Sen. Christiaens moved SB 291 as amended. All Committee members voted yes, except Sen. Rye who voted no.

EXECUTIVE ACTION ON SB 285

Discussion:

Tom Gomez, Legislative Council, said he had met with the parties of Sen. Yellowtail's bill and Sen. Franklin's bill. Currently, he has about 38 pages of unedited material of a substitute bill. Depending upon the choices of the Committee, things may be added to the substitute bill, or left separate, such as anti-trust language.

Chairman Eck said her understanding was that some decisions had to be made in areas where there may not be unanimous agreement among the different groups working on SB 285. The first decision to be made concerns the naming of the Authority, and whether the Authority will be a group of employed persons or a volunteer board. Chairman Eck asked Sen. Franklin to begin the discussion of this issue.

Sen. Franklin said SB 285 asks for an appointed (unpaid) Board because the state does not have the money to pay the Board members and their experience was that the kinds of individuals they would want appointed to this Board would be "overachievers" with a strong interest in change and who function well in that mode. Another argument is that there may be flexibility as to the make up of the Board. Paid Board members may have an interest in seeing the Board continue. The (volunteer) Board members would be reimbursed as other board members are, and there would also be a paid staff.

Sen. Christiaens asked Sen. Franklin if the discussion pertained to paying only those members of the main authority. Sen. Franklin said that was correct, but that another issue was the membership of the regional boards.

Chairman Eck said paid Board members would be seen as board members and staff as well. A Board doing the decision-making can provide some protection for the staff doing the work. Otherwise, (paid) Board members doing the work would "get hammered" all the time.

Clyde Dailey (Exhibit #5) said their ultimate decision was there was so much to do, given the provisions of SB 285, it was not practical to ask volunteers to do it on a per diem wage. There was also the concern that, with a volunteer board, there was the potential of ex-officio members dominating the board. Mr. Dailey said this is also an educational board.

Sen. Klampe said he wanted to know what kinds of people would be selected to serve on the Board. He said it would be difficult to get a physician to leave his profession for this.

Sen. Franklin said the Majority Leader and the Minority Leader of the House and of the Senate would each come up with a list of five individuals who are recognized as "experts in their field." These names are submitted to the Governor, and the Governor chooses five individuals from the list of ten. SB 285 states that those individuals must be acknowledged for their experience, expertise or interest in health care, and one of those people should be a consumer advocate.

Sen. Klampe said it would be difficult to obtain four health care experts who will quit their jobs for two years.

Sen. Franklin said that it is important for the Committee to

understand that if an individual is a volunteer, he is not expected to quit his job.

Tom Gomez said the next issue for the Committee to address concerns the make up of the regional health care planning boards. The issue was that each board contain one member from each county of the respective regions to be formed.

Clyde Dailey said there needed to be representation that would insure rural input into the regional planning process. The language currently in SB 285 sets the regional boards at five individuals each. They suggest three districts, with one district having 12 members, one having 11, and one with 9. Counties would have the option to petition out of a certain region and into another.

Sen. Mesaros asked Mr. Dailey if his recommendation were to have one representative per county in three regions. Mr. Dailey said that would be in five regions. He said the regions are still flexible.

Sen. Christiaens asked whether or not the regions are made the same as the mental health regions. These regions have been in existence for a long time and they have a history of working together.

Chairman Eck said they were the same regions for the Department of Family Services.

Sen. Franklin said her understanding was that the Committee might accept the Department of Health's recommendations for the regions, which is based on referral patterns. The issue, at this point, is the membership to those regional boards; should the membership be one from each county or limited to five.

Sen. Christiaens said his concern with a group this large, it is difficult to have a quorum present at the meetings.

Chairman Eck said she liked leaving the decision of how to appoint the members of the regional boards up to the Authority.

Sen. Mesaros said his concern was that rural health care be a focus in this process, and for that reason he agrees with the proposal outlined by Mr. Dailey.

Sen. Franklin said there was a concern for the rurality issue in SB 285.

Chairman Eck asked if language stating that each regional board should have "at least five members" would help. Then it would be up to the Authority.

Sen. Franklin asked Sen. Mesaros if language assuring rural representation would be satisfactory. Sen. Mesaros said he was

fearful that the regional board would be made up of five members from the major city in that region.

Sen. Franklin said 56 individuals is too many.

Christian Mackay said that if each county is not represented, then there may be a conflict of interest, and there is the potential of rural areas furthering their loss of access. He didn't see that all 56 individuals would have to be together at once in either SB 267 or SB 285, but he does see regions planning among themselves.

Chairman Eck said the Committee might add that qualification for "rural and urban interests" on Page 14, Subsection 2 of the original bill. Therefore, each board would have at least one member representing rural or urban interests. Chairman Eck asked the Committee if they wanted to amend or leave the language as it is.

Sen. Franklin asked Sen. Mesaros if language would help remedy his concerns. Sen. Mesaros said he couldn't respond, but it was an issue that needed to be addressed.

Tom Gomez pointed out that a statement of intent would be required because there are provisions that the Authority would establish "by rule" the make up of the regional boards. How the Legislature wants the Authority to act in establishing the regional boards could be included in the statement of intent.

Motion:

Sen. Mesaros moved that language for rural representation be included in the statement of intent. Sen. Franklin supported the motion.

Discussion:

Chairman Eck said anti-trust amendments should wait until Sen. Towe returns so he could review them.

Tom Gomez said as SB 285 is currently prepared, it contains the list of regions because that was recommended in the amendment. (Exhibit #6) He said he could keep Section 10, which states that the Authority shall establish by rule a maximum of five planning regions.

Clyde Dailey said their regions were different than those proposed by the Department of Health, which are the same as the mental health regions.

Sen. Franklin said she had no problem with accepting the Department of Health regions and inserting that into SB 285.

Chairman Eck asked if they were the same as the mental health

regions. Sen. Franklin said she did not know, and it could wait.

Sen. Christiaens said most of the Committee members had not seen the amendments.

Sen. Franklin said she was happy to leave SB 285 as it is now, but if there is a strong feeling that the regions be established ahead of time, she will go along with that.

Susan Fox said there are sections from Sen. Nathe's bill draft request concerning the health care database and statistics which has not been incorporated in SB 285 as of yet.

Chairman Eck said the language clarifies that there will be only one health care database in the state of Montana.

Sen. Franklin said she would check to see if the Department of Health regions were the same as the mental health regions, and if the language regarding the database were necessary for the Robert Wood Johnson grant.

Tom Gomez said the Committee should address the issue of small group insurance reform. There are extensive amendments offered by the Commissioner of Insurance.

Sen. Christiaens asked if these amendments were printed. Susan Fox said the amendments were distributed February 10th, but the Committee doesn't have printed copies of the sections from Sen. Nathe's bill or the amendments from the Department of Health.

Sen. Franklin said she would be willing to accept the Insurance Commissioner's amendments. (Exhibit #17)

Chairman Eck said the two bills addressed by Sen. Christiaens and the amendments offered by the Insurance Commissioner were not compatible.

Carol Roy, State Auditor's Office, said she believed that Sen. Christiaen's bill would affect all disability insurance, whereas SB 285 affects only small group insurance.

Tom Gomez asked for permission to strike those provisions regarding the small employer health insurance as currently contained in SB 285 or to leave those provisions in to make it easier for the Committee members to address.

Sen. Franklin said she would accept the Insurance Commissioner's amendments as a substitute for what is currently in SB 285. Chairman Eck allowed this as an amendment to SB 285 without objection without the Committee's endorsement. Anti-trust will not be addressed until Sen. Towe returns.

Sen. Klampe asked if the Committee had accepted the Insurance Commissioner's amendments, but other amendments can still be

worked on. Chairman Eck said that was correct.

Sen. Klampe asked if there was a definite time the Committee would be taking Executive Action on SB 285. Chairman Eck said the Committee would meet on adjournment on Thursday, February 18.

Clyde Dailey asked Chairman Eck whether the Committee would act on the decision to pay the Authority Board members. Chairman Eck said the Committee would not act on it because there was no motion to change SB 285.

Chairman Eck said once the Committee receives the new draft, there will be an opportunity to change it.

HEARING ON SB 366

Opening Statement by Sponsor:

Sen. Dennis Nathe, Senate District 10, said he received a lot of calls in favor of the bill, but he didn't see many proponents at the hearing. There is a problem with speech pathologists and the programs they provide in the school systems. None of the Montana universities or colleges has a speech pathology program, and there is a master's degree requirement for licensure. Sen. Nathe provided a hand-out for the Committee (Exhibit #7), and went over Page 2. The problem is that superintendents are having trouble hiring speech pathologists because of the shortage and the cost of supervision. SB 366 allows a bachelor's degree to be enough to receive a speech pathologist license. Sen. Nathe provided another hand-out for the Committee. (Exhibit #8)

Proponents' Testimony:

None.

Opponents' Testimony:

Allison Failing, Glasgow, said she had just finished her master's degree at Washington State University. She said she had hoped to work in Poplar, and she had been contacted by the Poplar School District to apply there. On December 18, 1992, she was at the Poplar school, but had received no reply to her applications. The Secretary told Ms. Failing that she could not be hired because the Poplar school could not afford to hire her.

Beverly Roy, member of the Board of Speech Language Pathologists and Audiologists, provided written testimony. (Exhibit #9)

Kara Sheridan, student at Washington State University, said she will receive her bachelor's degree in May. Ms. Sheridan is currently doing an internship in Missoula where she is learning the importance of furthering her education. While obtaining a

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-17-93

[illegible]

FC8

Attach to each day's minutes

165

Page , Section , Line

Strike:

Insert: "All the authority members must be full-time state employees, exempt from Title 2, chapter 18, parts 1 and 2. The annual salary of the presiding officer is 85% of the annual salary of the presiding officer of the public service commission. The annual salary of each of the other members is 85% of the annual salary of public service commissioners other than the presiding officer."

Amendments to Senate Bill 285

SENATE HEALTH & WELFARE

ENROLL NO

6

DATE

2-17-93

BILL NO

SB 285

Page , Section , Line

Strike:

Accepted

Insert: " NEW SECTION. Section . Health care planning regions. (1) There are five health care planning regions. Subject to subsection 2, the regions consist of the following counties.

(a) Region I: Valley, Daniels, Sheridan, Roosevelt, Garfield, McCone, Richland, Dawson, Wibaux, Prairie, Fallon, and Carter;

(b) Region II: Glacier, Toole, Liberty, Hill, Blaine, Phillips, Pondera, Chouteau, Teton, Cascade, Judith Basin, and Fergus;

(c) Region III: Custer, Powder River, Rosebud, Treasure, Petroleum, Musselshell, Golden Valley, Wheatland, Stillwater, Yellowstone, and Carbon;

(d) Region IV: Sweetgrass, Park, Meagher, Broadwater, Gallatin, Madison, Beaverhead, Silver Bow, Deer Lodge, Jefferson, and Lewis and Clark;

(e) Region V: Powell, Granite, Ravalli, Missoula, Mineral, Sanders, Lake, Flathead, and Lincoln;"

Page , Section , Line

Strike:

Insert: "Within each region, the authority shall establish by rule a regional health care planning board. Each board must include one member from each county within their respective regions. The members on each board must represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care.

Amendments to Senate Bill No. 285
First Reading Copy

SENATE HEALTH & WELFARE
EXHIBIT 17
DATE 2-17-93
BILL NO. SB 285

Requested by Sen. Eck
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan B. Fox
February 12, 1993

1. Title, line 15.
Following: "PROVIDING"
Strike: "FOR"
Insert: "A SMALL EMPLOYER"
2. Title, line 16.
Strike: "REFORM"
Insert: "ACT"
3. Page 3, line 3.
Strike: "section"
Insert: "sections"
4. Page 3, line 4.
Strike: "13"
Insert: "14, 17, 18, 21, and 25 through 27"
5. Page 3, line 9.
Following: "cost-effective"
Insert: "pursuant to the Small Employer Health Insurance Availability Act. The commissioner may adopt rules providing for a transition period to allow small employer carriers to comply with certain provisions of the act. The commissioner may approve the establishment of additional classes of businesses only if the commissioner determines that the additional classes would enhance the efficiency and fairness of the small employer health insurance market. The commissioner is required under the act to adopt rules to implement and administer the act"
6. Page 5, line 2.
Following: "sciences"
Insert: "and the commissioner of insurance"
7. Page 5, line 5.
Page 7, lines 2 and 6.
Strike: "13"
Insert: "12"
8. Page 5, line 21.
Following: "company"
Insert: "health service corporation,"
9. Page 18, line 4 through page 20, line 19.
Strike: section 13 in its entirety

Insert: "NEW SECTION. Section 13. Short title. [Sections 13 through 27] may be cited as the "Small Employer Health Insurance Availability Act".

NEW SECTION. Section 14. Purpose. (1) [Sections 13 through 27] must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to purchasers;

(d) to establish rules regarding renewability of coverage;

(e) to establish limitations on the use of preexisting condition exclusions;

(f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;

(g) to provide for the establishment of a reinsurance program; and

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) [Sections 13 through 27] are not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

NEW SECTION. Section 15. Definitions. As used in [sections 13 through 27], the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of [section 18], based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to [section 22].

(5) "Board" means the board of directors of the program established pursuant to [section 21].

(6) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the

Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of [section 13 through 27], companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claims experience, health status, and duration of coverage are not case characteristics for purposes of [sections 13 through 27].

(8) "Class of business" means all or a separate grouping of small employers established pursuant to [section 17].

(9) "Committee" means the health benefit plan committee created pursuant to [section 22].

(10) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined to be a dependent in the health benefit plan covering the employee.

(11) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(12) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(13) "Health benefit plan" means any hospital or medical policy or certificate issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(14) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(16) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Plan of operation" means the operation of the program established pursuant to [section 21].

(18) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(19) "Program" means the Montana small employer health reinsurance program created by [section 21].

(20) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided

that the policy has been in effect for a period of at least 1 year.

(21) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to [section 21].

(23) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(24) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(26) "Standard health benefit plan" means a health benefit plan developed pursuant to [section 22].

NEW SECTION. Section 16. Applicability and scope. [Sections 13 through 26] apply to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

NEW SECTION. Section 17. Establishment of classes of business. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or

more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner may adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. Section 18. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under [sections 13 through 27] are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate; or

(ii) if the Montana health care authority established by [section 1] certifies to the commissioner that the cost containment goal set forth in [section 5] is met on or before January 1, 1999, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage may not vary from the index by more than 20% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a

change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) Premium rates for health benefit plans must comply with the requirements of this section, notwithstanding any assessments paid or payable by small employer carriers pursuant to [section 21].

(f) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

(g) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(ii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(h) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(i) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner.

(k) The commissioner may adopt rules to implement the

provisions of this section and to ensure that rating practices used by small employer carriers are consistent with the purposes of [sections 13 through 27], including rules that ensure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences because of the nature of the groups.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with [sections 13 through 27] and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of [sections 13 through 27] and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

NEW SECTION. Section 19. Renewability of coverage. (1) A health benefit plan subject to the provisions of [sections 13 through 27] is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

- (a) nonpayment of the required premium;
- (b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;
- (c) noncompliance with the carrier's minimum participation requirements;
- (d) noncompliance with the carrier's employer contribution requirements;
- (e) repeated misuse of a restricted network provision;
- (f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:
 - (i) provide advance notice of this decision under this subsection (1) (f) to the commissioner in each state in which it is licensed; and
 - (ii) at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.
- (g) the commissioner finds that the continuation of the coverage would:
 - (i) not be in the best interests of the policyholders or certificate holders; or
 - (ii) impair the carrier's ability to meet its contractual obligations.
- (2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.
- (3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.
- (4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area.

NEW SECTION. Section 20. Availability of coverage -- required plans. (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with [sections 13 through 27].

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to [section 17], the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to [section 22], provided that if the program created pursuant to [section 21] is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of [sections 13 through 27].

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit

plan may not define a preexisting condition more restrictively than 33-22-216, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of

the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

NEW SECTION. Section 21. Small employer carrier reinsurance program -- board membership -- plan of operation -- criteria -- exemption from taxation. (1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2) (a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

(ii) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.

(3) Within [60 days of the effective date of this section], each small employer carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued to small employers in this state in the previous calendar year.

(4) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan

necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(5) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(6) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(e) provide for any additional matters necessary for the implementation and administration of the program.

(7) The program must have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program must have the specific authority to:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of [sections 13 through 27], including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of [sections 13 through 27];

(e) establish rules, conditions, and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program; and

(h) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection (8):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group business in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(9) (a) As part of the plan of operation, the board shall

establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (9)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under [sections 13 through 27].

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (9).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (9).

(c) The board periodically shall review the methodology established under subsection (9)(a), including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(10) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in [section 18].

(11) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) A net loss for the year must be reimbursed by the commissioner from funds specifically appropriated for that purpose.

(12) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by [sections 13 through 27] may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(13) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards,

the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program is exempt from taxation.

NEW SECTION. Section 22. Health benefit plan committee -- recommendations. (1) The commissioner shall appoint a health benefit plan committee. The committee is composed of representatives of carriers, small employers and employees, health care providers, and producers.

(2) The committee shall recommend the form and level of coverages to be made by small employer carriers pursuant to [section 20].

(3) (a) The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan that contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(b) The plans recommended by the committee must include cost containment features, such as:

(i) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(ii) case management;

(iii) selective contracting with hospitals, physicians, and other health care providers;

(iv) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(v) other managed care provisions.

(c) The committee shall submit the health benefit plans described in subsections (3)(a) and (3)(b) to the commissioner for approval within 180 days after the appointment of the committee.

NEW SECTION. Section 23. Periodic market evaluation -- report. The board, in consultation with members of the committee, shall study and report at least every 3 years to the commissioner on the effectiveness of [sections 13 through 27]. The report must analyze the effectiveness of [sections 13 through 27] in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of [sections 13 through 27]. The report may contain recommendations for market conduct or other regulatory standards or action.

NEW SECTION. Section 24. Waiver of certain laws. A law that requires the inclusion of a specific category of licensed health care practitioner does not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 13 through 27].

NEW SECTION. Section 25. Administrative procedure. The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and administer [sections 13 through 27].

NEW SECTION. Section 26. Standards to ensure fair marketing. (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the

program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

NEW SECTION. Section 27. Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after [the effective date of this section], to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after [6 months prior to the effective date of this section]. The commissioner may prescribe the terms for the reissuance of coverage that the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers."

Renumber: subsequent sections

10. Page 22, line 23.

Strike: "13(10) through (12), 14, 15"

Insert: "28, 29"

11. Page 22, line 25 through page 23, line 1.

Strike: "Section 13(1)"

Insert: "Sections 13"

Strike: "(9)] is"

Insert: "27] are"

Strike: "[1 year" on page 22, line 25 through "act]" on page 23, line 1.

2-17-93
SB-285

Insert: "January 1, 1994"

12. Page 23, line 6.

Page 23, line 8.

Strike: "13"

Insert: "12 and 28"

13. Page 23, line 9.

Following: line 8

Insert: "(3) [Sections 13 through 27] are intended to be
codified as an integral part of Title 33, and the provisions
of Title 33 apply to [sections 13 through 27]."

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
 BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN,
 VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB,
 CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE,
 COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE,
 DOWELL, RUSSELL, STANFORD, TUSS, DOLEZAL, DOHERTY,
 PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN,
 WELDON, KENNEDY, WILSON, BARTLETT,
 SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST
 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
~~REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON~~
~~LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH~~
~~PLANNING REGIONS AND BOARDS~~ REQUIRING DEVELOPMENT OF UNIFORM
CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO
CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM
CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
UNIFIED HEALTH CARE DATA BASE; PROVIDING---FOR---HEALTH
INSURANCE---REFORM REQUIRING HEALTH INSURER COST MANAGEMENT
PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
SCIENCES RELATING TO VITAL-STATISTICS STATE HEALTH PLANNING;
PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
ACT; AMENDING SECTION 50-15-101 50-1-201, MCA; AND PROVIDING
EFFECTIVE DATES."

STATEMENT OF INTENT

~~A--statement--of--legislative--intent--is--required--for--this~~
~~bill--because--{section--10}--requires--the--Montana--health--care~~
~~authority--to--adopt--rules--establishing--a--maximum--of--five~~
~~health--care--planning--regions--to--establish--regional--health~~
~~care--planning--boards--within--those--regions--and--to--establish~~
~~a--procedure--for--selection--of--regional--board--members--The~~

THERE ARE NO CHANGES IN THIS BILL
 AND WILL NOT BE REPRINTED. PLEASE
 REFER TO YELLOW COPY FOR COMPLETE TEXT.

APPROVED BY COMMITTEE
ON PUBLIC HEALTH, WELFARE
& SAFETY

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN,
VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB,
CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE,
COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE,
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CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM
CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
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HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
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UNIFIED HEALTH CARE DATA BASE; PROVIDING---FOR---HEALTH
INSURANCE---REFORM REQUIRING HEALTH INSURER COST MANAGEMENT
PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
SCIENCES RELATING TO VITAL-STATISTICS STATE HEALTH PLANNING;
PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
ACT; AMENDING SECTION 50-15-101 50-1-201, MCA; AND PROVIDING
EFFECTIVE DATES."

STATEMENT OF INTENT

~~A--statement--of--legislative--intent--is--required--for--this~~
~~bill--because--{section--10}--requires--the--Montana--health--care~~
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~~health--care--planning--regions--to--establish--regional--health~~
~~care--planning--boards--within--those--regions--and--to--establish~~
~~a--procedure--for--selection--of--regional--board--members--The~~
~~legislature--intends--that--the--rules--establishing--the--health~~
~~care--planning--regions--be--based--primarily--upon--the--geographic~~
~~health--care--referral--patterns--by--which--health--care--providers~~
~~refer--patients--to--specialists--or--larger--health--care~~
~~facilities--These--rules--should--also--consider--communication~~
~~and--transportation--patterns--and--natural--barriers--to--these~~
~~patterns--The--rules--establishing--the--boards--must--specify--the~~

number--of--members,--any--relevant--qualifications,--and--the
operations--and--duties--of--the--boards--and--must--provide--for--a
funding--mechanism--by--grant--from--the--authority. The procedure
for--selection--of--the--board--members--must--provide--for--public
notice--of--the--selection--process.

A statement of intent is also required because--{section
12}--requires--the--authority--to--adopt--rules--relating--to--the
unified health care data base. The authority's--rules--must
specify in comprehensive detail what information is required
to--be--provided--by--health--care--providers--and--the--times--at
which the information is to be provided. The rules must also
provide for audit procedures to determine--the--accuracy--of
the--filed--data. The confidentiality provisions must be
consistent---with---other---state---laws---governing---the
confidentiality---of---public---records, including medical
records, and must apply to employees of the authority and to
others receiving or using records in the data base.

A statement of intent is also required because--{section
13}--requires--the--commissioner--of--insurance--to--adopt--rules
governing small employer group health plans. In determining
the--basic--benefits--package, the commissioner shall make
objective--determinations, supported--by--available---data,
concerning the type of benefits required and shall determine
that--the--benefits--to--be--required--are--cost-effective. A
STATEMENT OF LEGISLATIVE INTENT IS REQUIRED FOR THIS BILL

BECAUSE:

(1) [SECTION 4] AUTHORIZES THE MONTANA HEALTH CARE
AUTHORITY TO ADOPT RULES NECESSARY TO IMPLEMENT [SECTIONS 1
THROUGH 20]. IN ADDITION TO THOSE RULEMAKING MATTERS
ADDRESSED BELOW, THE AUTHORITY MAY ADOPT RULES GOVERNING
SUCH MATTERS AS ITS MEETINGS, PUBLIC HEARINGS, AND RULES OF
PROCEDURE AND RULES OF ETHICAL CONDUCT GOVERNING ITS
MEMBERS.

(2) [SECTION 17] REQUIRES THE MONTANA HEALTH CARE
AUTHORITY TO ADOPT RULES TO ESTABLISH REGIONAL HEALTH CARE
PLANNING BOARDS WITHIN THE HEALTH CARE PLANNING REGIONS
ESTABLISHED IN [SECTION 17] AND TO ESTABLISH A PROCEDURE FOR
SELECTION OF REGIONAL BOARD MEMBERS. THE RULES ESTABLISHING
THE BOARDS MUST SPECIFY THE NUMBER OF MEMBERS, ANY RELEVANT
QUALIFICATIONS, AND THE OPERATIONS AND DUTIES OF THE BOARDS
AND MUST PROVIDE FOR A FUNDING MECHANISM BY GRANT FROM THE
AUTHORITY. IN ADDITION, THE RULES MUST PROVIDE FOR
CONSIDERATION OF A BALANCE BETWEEN RURAL AND URBAN INTERESTS
IN THE SELECTION OF REGIONAL BOARD MEMBERS. THE PROCEDURE
FOR SELECTION OF THE BOARD MEMBERS MUST PROVIDE FOR PUBLIC
NOTICE OF THE SELECTION PROCESS.

(3) [SECTION 10] GRANTS THE COMMISSIONER OF INSURANCE
THE AUTHORITY TO ADOPT RULES SPECIFYING UNIFORM HEALTH
INSURANCE CLAIM FORMS AND PROCEDURES. THE FORMS SHOULD BE
BASED UPON EXISTING FORMATS, BE AS SHORT AS POSSIBLE, AND BE

1 COMPATIBLE WITH ELECTRONIC DATA TRANSMISSION.

2 (4) [SECTION 19] REQUIRES THE AUTHORITY TO ADOPT RULES
 3 RELATING TO THE UNIFIED HEALTH CARE DATA BASE. THE
 4 AUTHORITY'S RULES MUST SPECIFY IN COMPREHENSIVE DETAIL WHAT
 5 INFORMATION IS REQUIRED TO BE PROVIDED BY HEALTH CARE
 6 PROVIDERS AND THE TIMES AT WHICH THE INFORMATION IS TO BE
 7 PROVIDED. THE RULES MUST ALSO PROVIDE FOR AUDIT PROCEDURES
 8 TO DETERMINE THE ACCURACY OF THE FILED DATA. THE
 9 CONFIDENTIALITY PROVISIONS MUST BE CONSISTENT WITH OTHER
 10 STATE LAWS GOVERNING THE CONFIDENTIALITY OF PUBLIC RECORDS,
 11 INCLUDING MEDICAL RECORDS, AND MUST APPLY TO EMPLOYEES OF
 12 THE AUTHORITY AND TO OTHERS RECEIVING OR USING RECORDS IN
 13 THE DATA BASE.

14 (5) [SECTIONS 23, 26, 27, 30, AND 34 THROUGH 36]
 15 REQUIRE THE COMMISSIONER OF INSURANCE TO ADOPT RULES
 16 GOVERNING SMALL EMPLOYER GROUP HEALTH PLANS. IN DETERMINING
 17 THE BASIC BENEFITS PACKAGE, THE COMMISSIONER SHALL MAKE
 18 OBJECTIVE DETERMINATIONS, SUPPORTED BY AVAILABLE DATA,
 19 CONCERNING THE TYPE OF BENEFITS REQUIRED AND SHALL DETERMINE
 20 THAT THE BENEFITS TO BE REQUIRED ARE COST-EFFECTIVE PURSUANT
 21 TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE
 22 COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION
 23 PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH
 24 CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE
 25 THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY

1 IF THE COMMISSIONER DETERMINES THAT THE ADDITIONAL CLASSES
 2 WOULD ENHANCE THE EFFICIENCY AND FAIRNESS OF THE SMALL
 3 EMPLOYER HEALTH INSURANCE MARKET. THE COMMISSIONER IS
 4 REQUIRED UNDER THE ACT TO ADOPT RULES TO IMPLEMENT AND
 5 ADMINISTER THE ACT.

6
 7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

8 (Refer to Introduced Bill)

9 Strike everything after the enacting clause and insert:

10 NEW SECTION. Section 1. State health care policy. (1)

11 It is the policy of the state of Montana to ensure that all
 12 residents have access to quality health services at costs
 13 that are affordable. To achieve this policy, it is necessary
 14 to develop a health care system that is integrated and
 15 subject to the direction and oversight of a single state
 16 agency. Comprehensive health planning through the
 17 application of a statewide health care resource management
 18 plan that is linked to a unified health care budget for
 19 Montana is essential.

20 (2) It is further the policy of the state of Montana
 21 that the health care system should:

22 (a) maintain and improve the quality of health care
 23 services offered to Montanans;

24 (b) contain or reduce increases in the cost of
 25 delivering services so that health care costs do not consume

a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(e) promote rational allocation of health care resources in the state; and

(f) facilitate universal access to preventive and medically necessary health care.

NEW SECTION. Section 2. Definitions. For the purposes of [sections 1 through 20], the following definitions apply:

(1) "Authority" means the Montana health care authority created by [section 3].

(2) "Board" means one of the regional health care planning boards created pursuant to [section 17].

(3) "Data base" means the unified health care data base created pursuant to [section 19].

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in

50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(5) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

(6) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(7) "Management plan" means the health care resource management plan required by [section 8].

(8) "Region" means one of the health care planning regions created pursuant to [section 17].

(9) "Statewide plan" means one of the statewide universal health care access plans for access to health care required by [section 5].

NEW SECTION. Section 3. Montana health care authority -- allocation -- membership. (1) There is a Montana health care authority.

(2) The authority is allocated to the department of

health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members appointed by the governor. At least one member must represent consumer organizations. Members of the authority must be appointed as follows:

(a) Within 30 days of [the effective date of this section], the majority and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(b) Within 30 days of [the effective date of this section], the majority and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as

original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

NEW SECTION. Section 4. Administration of health care authority -- reports -- compensation. (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The executive director is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The

executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with 50-1-201 and [sections 1 through 20];

(b) adopt rules necessary to implement [sections 1 through 20]; and

(c) enter into contracts and perform other acts necessary to accomplish the purposes of [sections 1 through 20].

(5) The authority shall report to the legislature and

the governor at least twice a year on its progress since the last report in fulfilling the requirements of [sections 1 through 20]. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

(6) Members of the authority must be paid and reimbursed as provided in 2-15-124.

(7) The authority shall make grants to the boards for the operation of the boards. The authority shall provide for uniform procedures for grant applications and budgets of the boards.

NEW SECTION. Section 5. Statewide universal access plans required. (1) On or before October 1, 1994, the authority shall submit a report to the legislature that contains the authority's recommendation for a statewide universal health care access plan based on a single payor system and a recommendation for a statewide universal access plan based on a regulated multiple payor system. Each statewide plan must contain recommendations that, if implemented, would provide for universally accessible, medically necessary, and preventive health care by October 1, 1995. Both plans must be voted on by the 1995 legislature no later than 45 days from the first day of the 1995 legislative session. The legislature may return one or both plans to the authority for further development.

(2) For purposes of this section:

(a) a single payor system is a method of financing health services predominantly through public funds so that each resident of Montana receives a uniform set of benefits as established through statute or administrative rule. Policies governing all aspects of the management of the single payor system would reside with state government, and benefits must be administered by a single entity.

(b) a regulated multiple payor system is a method of financing health services through a mix of public and private funds so that each resident of Montana receives a uniform set of benefits as established by statute or administrative rule. State government has responsibility for regulating the multiple entities that provide benefits to residents, including regulations for enrollment, change in premium rates, payment rates to providers, and aggregate health expenditures.

NEW SECTION. Section 6. Features of statewide plans.

(1) Each statewide plan under [section 5] must contain the features required by [sections 7 through 9 and 11] and this section.

(2) Each statewide plan must include:

- (a) guaranteed access to health care services for all residents of Montana;
- (b) a uniform system of health care benefits;
- (c) a unified health care budget;

(d) portability of coverage, regardless of job status;

(e) a broad-based, public or private financing mechanism to fund health care services;

(f) a system capped for provider expenditures;

(g) global budgeting for all health care spending;

(h) controlled capital expenditures;

(i) a binding cap on overall expenditures;

(j) policymaking for the system as a whole and accountability within state government;

(k) incentives to be used to contain costs and direct resources;

(l) administrative efficiencies;

(m) the appropriate use of midlevel practitioners, such as physician's assistants and nurse practitioners;

(n) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;

(o) integration, to the extent possible under federal and state law, of benefits provided under the health care system with benefits provided by the Indian health service and the United States department of veteran affairs and benefits provided by the medicare and medicaid programs; and

(p) an actuarially sound estimate of the costs of implementing the plan through the year 2005.

NEW SECTION. Section 7. Cost containment. (1) The

154

1 statewide plans must contain a cost containment component.
 2 Except as otherwise provided in this section, each statewide
 3 plan must establish a target for cost containment so that by
 4 1999, the annual average percentage increase in statewide
 5 health care costs does not exceed the average annual
 6 percentage increase in the gross domestic product, as
 7 determined by the U.S. department of commerce, for the 5
 8 preceding years.

9 (2) The authority shall adopt processes and criteria
 10 for responding to exceptional and unforeseen circumstances
 11 that affect the health care system and the target required
 12 in subsection (1), including such factors as population
 13 increases or decreases, demographic changes, costs beyond
 14 the control of health care providers, and other factors that
 15 the authority considers significant.

16 (3) The authority shall include the following features
 17 in the cost containment component:

18 (a) global budgeting for all health care spending;

19 (b) a system for limiting demand of health care
 20 services and controlling unnecessary and inappropriate
 21 health care. The system may include prioritization of
 22 services that allows for consideration of an individual
 23 patient's prognosis.

24 (c) a system for reimbursing health care providers for
 25 services and health care items. The reimbursement system

1 must provide that all payors, public or private, pay the
 2 same rate for the same health care services and items and
 3 that reimbursement for services is based predominantly upon
 4 the health care service provided rather than upon the
 5 discipline of the health care provider.

6 (d) a method of monitoring compliance with the target
 7 required in subsection (1);

8 (e) expenditure targets for health care providers and
 9 facilities;

10 (f) disincentives for exceeding the targets established
 11 pursuant to subsection (3)(e), including reduction of
 12 reimbursement levels in subsequent years;

13 (g) reimbursement of health care providers and health
 14 care facilities that is based upon negotiated annual budgets
 15 or fees for services; and

16 (h) a plan by the authority, health care providers,
 17 health insurers, and health care facilities to educate the
 18 public concerning the purpose and content of the statewide
 19 plans.

20 NEW SECTION. **Section 8. Health care resource**
 21 **management plan.** (1) Each statewide plan must contain a
 22 health care resource management plan that takes into account
 23 the provisions of [section 7]. The management plan must
 24 provide for the distribution of health care resources within
 25 the regions established pursuant to [section 17] and within

1 the state as a whole, consistent with the principles
2 provided in subsection (2).

3 (2) The management plan must include:

4 (a) a statement of principles used in the allocation of
5 resources and in establishing priorities for health
6 services;

7 (b) identification of the current supply and
8 distribution of:

9 (i) hospital, nursing home, and other inpatient
10 services;

11 (ii) home health and mental health services;

12 (iii) treatment services for alcohol and drug abuse;

13 (iv) emergency care;

14 (v) ambulatory care services, including primary care
15 resources;

16 (vi) nutrition benefits, prenatal benefits, and
17 maternity care;

18 (vii) human resources;

19 (viii) major medical equipment; and

20 (ix) health screening and early intervention services;

21 (c) a determination of the appropriate supply and
22 distribution of the resources and services identified in
23 subsection (2)(b) and of the mechanisms that will encourage
24 the appropriate integration of these services on a local or
25 regional basis. To arrive at a determination, the authority

1 shall consider the following factors:

2 (i) the needs of the statewide population, with special
3 consideration given to the development of health care
4 services in underserved areas of the state;

5 (ii) the needs of particular geographic areas of the
6 state;

7 (iii) the use of Montana facilities by out-of-state
8 residents;

9 (iv) the use of out-of-state facilities by Montana
10 residents;

11 (v) the needs of populations with special health care
12 needs;

13 (vi) the desirability of providing high-quality services
14 in an economical and efficient manner, including the
15 appropriate use of midlevel practitioners; and

16 (vii) the cost impact of these resource requirements on
17 health care expenditures;

18 (d) a component that addresses health promotion and
19 disease prevention and that is prepared by the department of
20 health and environmental sciences in a format established by
21 the authority;

22 (e) incentives to improve access to and use of
23 preventive care; primary care services, including mental
24 health services; and community-based care;

25 (f) incentives for healthy lifestyles;

(g) incentives to improve access to health care in underserved areas, including:

(i) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and

(ii) tax credits and other financial incentives to attract and retain health care professionals in underserved areas; and

(h) a component that addresses integration of the plan, to the extent allowed by state and federal law, with services provided by the Indian health service and by the United States department of veterans affairs and by the medicare and medicaid programs.

(3) In adopting the management plan, the authority shall consider the regional health resource plans recommended by regional panels.

(4) The management plan must be revised annually in a manner determined by the authority.

(5) Prior to adoption of the management plan, the authority shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the authority shall adopt the management plan, taking comments into consideration.

NEW SECTION. Section 9. Health care billing simplification. (1) Each statewide plan must contain a component providing for simplification and reduction of the costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing; and

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phasein of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

NEW SECTION. Section 10. Uniform claim forms and procedures. (1) By January 1, 1994, the commissioner of insurance, after consultation with the authority, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and

processing of claims, including the submission of claims by means of an electronic claims processing system.

(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.

NEW SECTION. **Section 11.** Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of a system for reducing the use of defensive medicine by adopting practice protocols that would give providers guidelines to follow for specific procedures;

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

(iii) propose any changes, including legislation, that it considers necessary, including measures for compensating victims of tortious injuries.

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority shall include in its plans legislation that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic

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1 power.

2 (4) The authority shall apply for waivers from federal
3 laws necessary to implement recommendations of the authority
4 enacted by the legislature and to implement those
5 recommendations not requiring legislation.

6 NEW SECTION. **Section 12.** Hearings on statewide plans.
7 The authority shall seek public comment on the development
8 of each statewide plan required under [section 5]. In
9 seeking public comment on the development of the authority's
10 recommendations for each plan, the authority shall provide
11 extensive, multimedia notice to the public and hold at least
12 one public hearing in each of the health care planning
13 regions established by [section 17]. The hearings must take
14 place before the authority's report is submitted to the
15 legislature. The authority shall consult with health care
16 providers in the development of its recommendations for each
17 statewide plan.

18 NEW SECTION. **Section 13.** State purchasing pool --
19 reports required. (1) On or before December 15, 1994, and
20 December 15, 1996, the authority shall report to the
21 legislature on establishment of a state purchasing pool,
22 including the number and types of groups and group members
23 participating in the pool, the costs of administering the
24 pool, the savings attributable to participating groups from
25 the operation of the pool, and any changes in legislation

1 considered necessary by the authority.

2 (2) On or before December 15, 1996, the authority shall
3 report to the legislature its recommendations concerning the
4 feasibility and merits of authorizing the authority to act
5 as an insurer in pooling risks and providing benefits,
6 including a common benefits plan, to participants of the
7 purchasing pool.

8 NEW SECTION. **Section 14.** Study of prescription drug
9 cost and distribution. The authority shall conduct a study
10 of the cost and distribution of prescription drugs in this
11 state. The study must consider the feasibility of various
12 methods of reducing the cost of purchasing and distributing
13 prescription drugs to Montana residents. The study must
14 include the feasibility of establishing a prescription drug
15 purchasing pool for distribution of drugs through
16 pharmacists in this state. The results of the study,
17 including the authority's recommendations for any necessary
18 legislation, must be reported to the legislature by December
19 1, 1996. If the authority determines that feasible methods
20 are available without need for legislation or
21 appropriations, the authority shall implement that part or
22 those parts of its recommendations.

23 NEW SECTION. **Section 15.** Long-term care study and
24 recommendations. (1) The authority shall conduct a study of
25 the long-term care needs of state residents and report to

the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on its report in each region established under [section 17]. The authority shall present its report to the legislature on or before January 1, 1997.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The authority's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The authority's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana and its citizens over the next 20 years if there is no change in the present accessibility, affordability, or financing of long-term care services in this state.

(4) The authority shall consult with the department of social and rehabilitation services in developing its

recommendations under this section.

NEW SECTION. Section 16. Study of certificate of need

process. (1) The authority shall conduct a study of the certificate of need process established under Title 50, chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the authority's recommendation for a single payor health care system required by [section 5]. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

NEW SECTION. Section 17. Health care planning regions and regional planning boards created -- selection -- membership. (1) There are five health care planning regions. Subject to subsection (2), the regions must consist of the following counties:

(a) region I: Sheridan, Daniels, Valley, Phillips, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and Carter;

(b) region II: Blaine, Hill, Liberty, Toole, Glacier, Pondera, Teton, Chouteau, and Cascade;

(c) region III: Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

(d) region IV: Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead;

(e) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

(2) (a) A county may, by written request of the board of county commissioners, petition the authority at any time to be removed from a health care planning region and added to another region.

(b) The authority shall grant or deny the petition after a public hearing. The authority shall give notice as the authority determines appropriate. The authority shall grant the petition if it appears by a preponderance of the evidence that the petitioning county's health care interests are more strongly associated with the region that the county seeks to join than with the region in which the county is

located. If the authority grants the petition, the county is considered for all purposes to be part of the health care planning region as approved by the authority.

(3) Within each region, the authority shall establish by rule a regional health care planning board. Each board must include one member from each county within the region. The members on each board shall represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care. Each regional board should attempt to achieve gender balance.

(4) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select the members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(5) Regional board members serve 4-year terms, except that of the board members initially selected, at least three members serve for 2 years, at least three members serve for 3 years, and at least three members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve a 4-year term. Board members must be

compensated and reimbursed in accordance with 2-15-124.

NEW SECTION. Section 18. Powers and duties of boards.

(1) A board shall:

(a) meet at the time and place designated by the presiding officer, but not less than quarterly;

(b) submit an annual budget and grant application to the authority at the time and in the manner directed by the authority;

(c) adopt procedures governing its meetings and other aspects of its day-to-day operations as the board determines necessary;

(d) develop regional health resource plans in the format determined by the authority that must address the health care needs of the region and address the development of health care services in underserved areas of the region and other matters;

(e) revise the regional plan annually;

(f) hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional board;

(g) transmit the regional plan to the authority at the time determined by the authority;

(h) apply to the authority for grant funds for operation of the regional board and account, in the manner specified by the authority, for grant funds provided by the

authority; and

(i) seek from local sources money to supplement grant funds provided by the authority.

(2) Regional boards may:

(a) recommend that the authority sanction voluntary agreements between health care providers and between health care consumers in the region that will improve the quality of, access to, or affordability of health care but that might constitute a violation of antitrust laws if undertaken without government direction;

(b) make recommendations to the authority regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by health care providers;

(c) undertake voluntary activities to educate consumers, providers, and purchasers and promote voluntary, cooperative community cost containment, access, or quality of care projects; and

(d) make recommendations to the department of health and environmental sciences or to the authority, or both, regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(3) Each regional board may review and advise the authority on regional technical matters relating to the

statewide plans required by [section 5], the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and facility contracts with the state, utilization review recommendations, expenditure targets, and uniform health care benefits and the impact of the benefits upon the provision of quality health care within the region.

NEW SECTION. Section 19. Health care data base -- information submitted -- enforcement. (1) The authority shall develop and maintain a unified health care data base that enables the authority, on a statewide basis, to:

(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;

(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and cost-effective health care;

(c) conduct evaluations of health care procedures and health care protocols;

(d) compare costs of commonly performed health care procedures between providers and health care facilities within a region and make the data readily available to the public; and

(e) compare costs of various health care procedures in one location of providers and health care facilities with

the costs of the same procedures in other locations of providers and health care facilities.

(2) The authority shall by rule require health care providers, health insurers, health care facilities, private entities, and entities of state and local governments to file with the authority the reports, data, schedules, statistics, and other information determined by the authority to be necessary to fulfill the purposes of the data base provided in subsection (1). Material to be filed with the authority may include health insurance claims and enrollment information used by health insurers.

(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.

(4) The data base must:

(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and

(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.

(5) Information in the data base required by law to be

kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

NEW SECTION. Section 20. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

(b) The authority may use plans filed under this section in the development of a unified health care budget.

(2) The plans required by this section must be developed in accordance with standards and procedures established by the authority.

(3) The provisions of this section do not apply to dental insurance.

Section 21. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is hereby--established--as the sole-and-official state

agency to administer the state program for comprehensive health planning and ~~is hereby authorized to~~ shall prepare a plan for comprehensive state health planning. The department ~~authority is authorized to~~ may confer and cooperate with any ~~and--all~~ other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department authority, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer any-and-all funds which-are now-available-or-which-may-be donated, granted, bequeathed, or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

NEW SECTION. Section 22. Short title. [Sections 22 through 36] may be cited as the "Small Employer Health Insurance Availability Act".

NEW SECTION. Section 23. Purpose. (1) [Sections 22 through 36] must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

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- 1 (b) to prevent abusive rating practices;
- 2 (c) to require disclosure of rating practices to
- 3 purchasers;
- 4 (d) to establish rules regarding renewability of
- 5 coverage;
- 6 (e) to establish limitations on the use of preexisting
- 7 condition exclusions;
- 8 (f) to provide for the development of basic and
- 9 standard health benefit plans to be offered to all small
- 10 employers;
- 11 (g) to provide for the establishment of a reinsurance
- 12 program; and
- 13 (h) to improve the overall fairness and efficiency of
- 14 the small employer health insurance market.
- 15 (2) [Sections 22 through 36] are not intended to
- 16 provide a comprehensive solution to the problem of
- 17 affordability of health care or health insurance.

18 **NEW SECTION. Section 24. Definitions.** As used in

19 [sections 22 through 36], the following definitions apply:

- 20 (1) "Actuarial certification" means a written statement
- 21 by a member of the American academy of actuaries or other
- 22 individual acceptable to the commissioner that a small
- 23 employer carrier is in compliance with the provisions of
- 24 [section 27], based upon the person's examination, including
- 25 a review of the appropriate records and of the actuarial

- 1 assumptions and methods used by the small employer carrier
- 2 in establishing premium rates for applicable health benefit
- 3 plans.

- 4 (2) "Affiliate" or "affiliated" means any entity or
- 5 person who directly or indirectly, through one or more
- 6 intermediaries, controls, is controlled by, or is under
- 7 common control with a specified entity or person.

- 8 (3) "Base premium rate" means, for each class of
- 9 business as to a rating period, the lowest premium rate
- 10 charged or that could have been charged under the rating
- 11 system for that class of business by the small employer
- 12 carrier to small employers with similar case characteristics
- 13 for health benefit plans with the same or similar coverage.

- 14 (4) "Basic health benefit plan" means a lower cost
- 15 health benefit plan developed pursuant to [section 31].

- 16 (5) "Board" means the board of directors of the program
- 17 established pursuant to [section 30].

- 18 (6) "Carrier" means any person who provides a health
- 19 benefit plan in this state subject to state insurance
- 20 regulation. The term includes but is not limited to an
- 21 insurance company, a fraternal benefit society, a health
- 22 service corporation, a health maintenance organization, and,
- 23 to the extent permitted by the Employee Retirement Income
- 24 Security Act of 1974, a multiple-employer welfare
- 25 arrangement. For purposes of [sections 22 through 36],

1 companies that are affiliated companies or that are eligible
2 to file a consolidated tax return must be treated as one
3 carrier, except that the following may be considered as
4 separate carriers:

5 (a) an insurance company or health service corporation
6 that is an affiliate of a health maintenance organization
7 located in this state;

8 (b) a health maintenance organization located in this
9 state that is an affiliate of an insurance company or health
10 service corporation; or

11 (c) a health maintenance organization that operates
12 only one health maintenance organization in an established
13 geographic service area of this state.

14 (7) "Case characteristics" means demographic or other
15 objective characteristics of a small employer that are
16 considered by the small employer carrier in the
17 determination of premium rates for the small employer,
18 provided that claims experience, health status, and duration
19 of coverage are not case characteristics for purposes of
20 [sections 22 through 36].

21 (8) "Class of business" means all or a separate
22 grouping of small employers established pursuant to [section
23 26].

24 (9) "Committee" means the health benefit plan committee
25 created pursuant to [section 31].

1 (10) "Dependent" means:

2 (a) a spouse or an unmarried child under 19 years of
3 age;

4 (b) an unmarried child, under 23 years of age, who is a
5 full-time student and who is financially dependent on the
6 insured;

7 (c) a child of any age who is disabled and dependent
8 upon the parent as provided in 33-22-506 and 33-30-1003; or

9 (d) any other individual defined to be a dependent in
10 the health benefit plan covering the employee.

11 (11) "Eligible employee" means an employee who works on
12 a full-time basis and who has a normal workweek of 30 hours
13 or more. The term includes a sole proprietor, a partner of a
14 partnership, and an independent contractor if the sole
15 proprietor, partner, or independent contractor is included
16 as an employee under a health benefit plan of a small
17 employer. The term does not include an employee who works on
18 a part-time, temporary, or substitute basis.

19 (12) "Established geographic service area" means a
20 geographic area, as approved by the commissioner and based
21 on the carrier's certificate of authority to transact
22 insurance in this state, within which the carrier is
23 authorized to provide coverage.

24 (13) "Health benefit plan" means any hospital or medical
25 policy or certificate issued by an insurance company, a

fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(14) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying

previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(16) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Plan of operation" means the operation of the program established pursuant to [section 30].

(18) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage

from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(19) "Program" means the Montana small employer health reinsurance program created by [section 30].

(20) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(21) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to [section 30].

(23) "Restricted network provision" means a provision of

a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(24) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(26) "Standard health benefit plan" means a health benefit plan developed pursuant to [section 31].

NEW SECTION. **Section 25. Applicability and scope.** [Sections 22 through 35] apply to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of

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the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

NEW SECTION. Section 26. Establishment of classes of business. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine

separate classes of business under subsection (1).

(3) The commissioner may adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. Section 27. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under [sections 22 through 36] are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate; or

(ii) if the Montana health care authority established by [section 3] certifies to the commissioner that the cost containment goal set forth in [section 7] is met on or before January 1, 1999, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage may not vary from the index by more than 20% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small

employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) Premium rates for health benefit plans must comply with the requirements of this section, notwithstanding any assessments paid or payable by small employer carriers pursuant to [section 30].

(f) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

(g) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that

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case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(ii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(h) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(i) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner.

(k) The commissioner may adopt rules to implement the provisions of this section and to ensure that rating practices used by small employer carriers are consistent with the purposes of [sections 22 through 36], including rules that ensure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences because of the nature of the groups.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the

1 insurance was issued.

2 (3) The commissioner may suspend for a specified period
3 the application of subsection (1)(a) for the premium rates
4 applicable to one or more small employers included within a
5 class of business of a small employer carrier for one or
6 more rating periods upon a filing by the small employer
7 carrier and a finding by the commissioner either that the
8 suspension is reasonable in light of the financial condition
9 of the small employer carrier or that the suspension would
10 enhance the fairness and efficiency of the small employer
11 health insurance market.

12 (4) In connection with the offering for sale of any
13 health benefit plan to a small employer, a small employer
14 carrier shall make a reasonable disclosure, as part of its
15 solicitation and sales materials, of each of the following:

16 (a) the extent to which premium rates for a specified
17 small employer are established or adjusted based upon the
18 actual or expected variation in claims costs or upon the
19 actual or expected variation in health status of the
20 employees of small employers and the employees' dependents;

21 (b) the provisions of the health benefit plan
22 concerning the small employer carrier's right to change
23 premium rates and the factors, other than claims experience,
24 that affect changes in premium rates;

25 (c) the provisions relating to renewability of policies

1 and contracts; and

2 (d) the provisions relating to any preexisting
3 condition.

4 (5) (a) Each small employer carrier shall maintain at
5 its principal place of business a complete and detailed
6 description of its rating practices and renewal underwriting
7 practices, including information and documentation that
8 demonstrate that its rating methods and practices are based
9 upon commonly accepted actuarial assumptions and are in
10 accordance with sound actuarial principles.

11 (b) Each small employer carrier shall file with the
12 commissioner annually, on or before March 15, an actuarial
13 certification certifying that the carrier is in compliance
14 with [sections 22 through 36] and that the rating methods of
15 the small employer carrier are actuarially sound. The
16 actuarial certification must be in a form and manner and
17 must contain information as specified by the commissioner. A
18 copy of the actuarial certification must be retained by the
19 small employer carrier at its principal place of business.

20 (c) A small employer carrier shall make the information
21 and documentation described in subsection (5)(a) available
22 to the commissioner upon request. Except in cases of
23 violations of the provisions of [sections 22 through 36] and
24 except as agreed to by the small employer carrier or as
25 ordered by a court of competent jurisdiction, the

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information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

NEW SECTION. Section 28. Renewability of coverage. (1)

A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of any

health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.

(g) the commissioner finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations.

(2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.

(3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.

(4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area.

NEW SECTION. Section 29. Availability of coverage -- required plans. (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with [sections 22 through 36].

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to [section 26], the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to [section 31], provided that if the program created pursuant to [section 30] is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small

1 employer carrier of a basic or standard health benefit plan
2 on the grounds that the plan does not meet the requirements
3 of [sections 22 through 36].

4 (3) Health benefit plans covering small employers must
5 comply with the following provisions:

6 (a) A health benefit plan may not, because of a
7 preexisting condition, deny, exclude, or limit benefits for
8 a covered individual for losses incurred more than 12 months
9 following the effective date of the individual's coverage. A
10 health benefit plan may not define a preexisting condition
11 more restrictively than 33-22-216, except that the condition
12 may be excluded for a maximum of 12 months.

13 (b) A health benefit plan must waive any time period
14 applicable to a preexisting condition exclusion or
15 limitation period with respect to particular services for
16 the period of time an individual was previously covered by
17 qualifying previous coverage that provided benefits with
18 respect to those services if the qualifying previous
19 coverage was continuous to a date not less than 30 days
20 prior to the submission of an application for new coverage.
21 This subsection (3)(b) does not preclude application of any
22 waiting period applicable to all new enrollees under the
23 health benefit plan.

24 (c) A health benefit plan may exclude coverage for late
25 enrollees for 18 months or for an 18-month preexisting

1 condition exclusion, provided that if both a period of
2 exclusion from coverage and a preexisting condition
3 exclusion are applicable to a late enrollee, the combined
4 period may not exceed 18 months from the date the individual
5 enrolls for coverage under the health benefit plan.

6 (d) (i) Requirements used by a small employer carrier
7 in determining whether to provide coverage to a small
8 employer, including requirements for minimum participation
9 of eligible employees and minimum employer contributions,
10 must be applied uniformly among all small employers that
11 have the same number of eligible employees and that apply
12 for coverage or receive coverage from the small employer
13 carrier.

14 (ii) A small employer carrier may vary the application
15 of minimum participation requirements and minimum employer
16 contribution requirements only by the size of the small
17 employer group.

18 (e) (i) If a small employer carrier offers coverage to
19 a small employer, the small employer carrier shall offer
20 coverage to all of the eligible employees of a small
21 employer and their dependents. A small employer carrier may
22 not offer coverage only to certain individuals in a small
23 employer group or only to part of the group, except in the
24 case of late enrollees as provided in subsection (3)(c).

25 (ii) A small employer carrier may not modify a basic or

standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would

place the small employer carrier in a financially impaired condition.

NEW SECTION. **Section 30.** Small employer carrier reinsurance program -- board membership -- plan of operation -- criteria -- exemption from taxation. (1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2) (a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of

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1 business or in the practice of a profession. One member of
 2 the board must be a small employer who is not active in the
 3 health care or insurance fields. One member of the board
 4 must be a representative of the general public who is
 5 employed by a small employer and is not employed in the
 6 health care or insurance fields.

7 (ii) The initial board members' terms are as follows:
 8 one-third of the members shall serve a term of 1 year;
 9 one-third of the members shall serve a term of 2 years; and
 10 one-third of the members shall serve a term of 3 years.
 11 Subsequent board members shall serve for a term of 3 years.
 12 A board member's term continues until that member's
 13 successor is appointed.

14 (iii) A vacancy on the board must be filled by the
 15 commissioner. The commissioner may remove a board member for
 16 cause.

17 (3) Within [60 days of the effective date of this
 18 section], each small employer carrier shall file with the
 19 commissioner the carrier's net health insurance premium
 20 derived from health benefit plans issued to small employers
 21 in this state in the previous calendar year.

22 (4) Within 180 days after the appointment of the
 23 initial board, the board shall submit to the commissioner a
 24 plan of operation and may at any time submit amendments to
 25 the plan necessary or suitable to ensure the fair,

1 reasonable, and equitable administration of the program. The
 2 commissioner may, after notice and hearing, approve the plan
 3 of operation if the commissioner determines it to be
 4 suitable to ensure the fair, reasonable, and equitable
 5 administration of the program and if the plan of operation
 6 provides for the sharing of program gains or losses on an
 7 equitable and proportionate basis in accordance with the
 8 provisions of this section. The plan of operation is
 9 effective upon written approval by the commissioner.

10 (5) If the board fails to submit a suitable plan of
 11 operation within 180 days after its appointment, the
 12 commissioner shall, after notice and hearing, promulgate and
 13 adopt a temporary plan of operation. The commissioner shall
 14 amend or rescind any temporary plan adopted under this
 15 subsection at the time a plan of operation is submitted by
 16 the board and approved by the commissioner.

17 (6) The plan of operation must:

18 (a) establish procedures for the handling and
 19 accounting of program assets and money and for an annual
 20 fiscal reporting to the commissioner;

21 (b) establish procedures for selecting an administering
 22 carrier and setting forth the powers and duties of the
 23 administering carrier;

24 (c) establish procedures for reinsuring risks in
 25 accordance with the provisions of this section;

1 (d) establish procedures for collecting assessments
2 from reinsuring carriers to fund claims and administrative
3 expenses incurred or estimated to be incurred by the
4 program; and

5 (e) provide for any additional matters necessary for
6 the implementation and administration of the program.

7 (7) The program must have the general powers and
8 authority granted under the laws of this state to insurance
9 companies and health maintenance organizations licensed to
10 transact business, except the power to issue health benefit
11 plans directly to either groups or individuals. In addition,
12 the program must have the specific authority to:

13 (a) enter into contracts as are necessary or proper to
14 carry out the provisions and purposes of [sections 22
15 through 36], including the authority, with the approval of
16 the commissioner, to enter into contracts with similar
17 programs of other states for the joint performance of common
18 functions or with persons or other organizations for the
19 performance of administrative functions;

20 (b) sue or be sued, including taking any legal actions
21 necessary or proper to recover any assessments and penalties
22 for, on behalf of, or against the program or any reinsuring
23 carriers;

24 (c) take any legal action necessary to avoid the
25 payment of improper claims against the program;

1 (d) define the health benefit plans for which
2 reinsurance will be provided and to issue reinsurance
3 policies in accordance with the requirements of [sections 22
4 through 36];

5 (e) establish rules, conditions, and procedures for
6 reinsuring risks under the program;

7 (f) establish actuarial functions as appropriate for
8 the operation of the program;

9 (g) appoint appropriate legal, actuarial, and other
10 committees as necessary to provide technical assistance in
11 operation of the program, policy and other contract design,
12 and any other function within the authority of the program;
13 and

14 (h) borrow money to effect the purposes of the program.
15 Any notes or other evidence of indebtedness of the program
16 not in default are legal investments for carriers and may be
17 carried as admitted assets.

18 (8) A reinsuring carrier may reinsure with the program
19 as provided for in this subsection (8):

20 (a) With respect to a basic health benefit plan or a
21 standard health benefit plan, the program shall reinsure the
22 level of coverage provided and, with respect to other plans,
23 the program shall reinsure up to the level of coverage
24 provided in a basic or standard health benefit plan.

25 (b) A small employer carrier may reinsure an entire

1 employer group within 60 days of the commencement of the
2 group's coverage under a health benefit plan.

3 (c) A reinsuring carrier may reinsure an eligible
4 employee or dependent within a period of 60 days following
5 the commencement of coverage with the small employer. A
6 newly eligible employee or dependent of the reinsured small
7 employer may be reinsured within 60 days of the commencement
8 of coverage.

9 (d) (i) The program may not reimburse a reinsuring
10 carrier with respect to the claims of a reinsured employee
11 or dependent until the carrier has incurred an initial level
12 of claims for the employee or dependent of \$5,000 in a
13 calendar year for benefits covered by the program. In
14 addition, the reinsuring carrier is responsible for 20% of
15 the next \$100,000 of benefit payments during a calendar year
16 and the program shall reinsure the remainder. A reinsuring
17 carrier's liability under this subsection (d)(i) may not
18 exceed a maximum limit of \$25,000 in any calendar year with
19 respect to any reinsured individual.

20 (ii) The board annually shall adjust the initial level
21 of claims and maximum limit to be retained by the carrier to
22 reflect increases in costs and utilization within the
23 standard market for health benefit plans within the state.
24 The adjustment may not be less than the annual change in the
25 medical component of the consumer price index for all urban

1 consumers of the United States department of labor, bureau
2 of labor statistics, unless the board proposes and the
3 commissioner approves a lower adjustment factor.

4 (e) A small employer carrier may terminate reinsurance
5 with the program for one or more of the reinsured employees
6 or dependents of a small employer on any anniversary of the
7 health benefit plan.

8 (f) A small employer group business in effect before
9 January 1, 1994, may not be reinsured by the program until
10 January 1, 1997, and then only if the board determines that
11 sufficient funding sources are available.

12 (g) A reinsuring carrier shall apply all managed care
13 and claims-handling techniques, including utilization
14 review, individual case management, preferred provider
15 provisions, and other managed care provisions or methods of
16 operation consistently with respect to reinsured and
17 nonreinsured business.

18 (9) (a) As part of the plan of operation, the board
19 shall establish a methodology for determining premium rates
20 to be charged by the program for reinsuring small employers
21 and individuals pursuant to this section. The methodology
22 must include a system for classification of small employers
23 that reflects the types of case characteristics commonly
24 used by small employer carriers in the state. The
25 methodology must provide for the development of base

1 reinsurance premium rates that must be multiplied by the
 2 factors set forth in subsection (9)(b) to determine the
 3 premium rates for the program. The base reinsurance premium
 4 rates must be established by the board, subject to the
 5 approval of the commissioner, and must be set at levels that
 6 reasonably approximate gross premiums charged to small
 7 employers by small employer carriers for health benefit
 8 plans with benefits similar to the standard health benefit
 9 plan, adjusted to reflect retention levels required under
 10 [sections 22 through 36].

11 (b) Premiums for the program are as follows:

12 (i) An entire small employer group may be reinsured for
 13 a rate that is one and one-half times the base reinsurance
 14 premium rate for the group established pursuant to this
 15 subsection (9).

16 (ii) An eligible employee or dependent may be reinsured
 17 for a rate that is five times the base reinsurance premium
 18 rate for the individual established pursuant to this
 19 subsection (9).

20 (c) The board periodically shall review the methodology
 21 established under subsection (9)(a), including the system of
 22 classification and any rating factors, to ensure that it
 23 reasonably reflects the claims experience of the program.
 24 The board may propose changes to the methodology that are
 25 subject to the approval of the commissioner.

1 (d) The board may consider adjustments to the premium
 2 rates charged by the program to reflect the use of effective
 3 cost containment and managed care arrangements.

4 (10) If a health benefit plan for a small employer is
 5 entirely or partially reinsured with the program, the
 6 premium charged to the small employer for any rating period
 7 for the coverage issued must meet the requirements relating
 8 to premium rates set forth in [section 27].

9 (11) (a) Prior to March 1 of each year, the board shall
 10 determine and report to the commissioner the program net
 11 loss for the previous calendar year, including
 12 administrative expenses and incurred losses for the year,
 13 taking into account investment income and other appropriate
 14 gains and losses.

15 (b) A net loss for the year must be reimbursed by the
 16 commissioner from funds specifically appropriated for that
 17 purpose.

18 (12) The participation in the program as reinsuring
 19 carriers; the establishment of rates, forms, or procedures;
 20 or any other joint collective action required by [sections
 21 22 through 36] may not be the basis of any legal action,
 22 criminal or civil liability, or penalty against the program
 23 or any of its reinsuring carriers, either jointly or
 24 separately.

25 (13) The board, as part of the plan of operation, shall

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develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program is exempt from taxation.

NEW SECTION. Section 31. Health benefit plan committee

-- recommendations. (1) The commissioner shall appoint a health benefit plan committee. The committee is composed of representatives of carriers, small employers and employees, health care providers, and producers.

(2) The committee shall recommend the form and level of coverages to be made by small employer carriers pursuant to [section 29].

(3) (a) The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan that contain benefit and cost-sharing levels that are consistent with the basic

method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(b) The plans recommended by the committee must include cost containment features, such as:

(i) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(ii) case management;

(iii) selective contracting with hospitals, physicians, and other health care providers;

(iv) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(v) other managed care provisions.

(c) The committee shall submit the health benefit plans described in subsections (3)(a) and (3)(b) to the commissioner for approval within 180 days after the appointment of the committee.

NEW SECTION. Section 32. Periodic market evaluation --

report. The board, in consultation with members of the committee, shall study and report at least every 3 years to the commissioner on the effectiveness of [sections 22 through 36]. The report must analyze the effectiveness of [sections 22 through 36] in promoting rate stability,

product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of [sections 22 through 36]. The report may contain recommendations for market conduct or other regulatory standards or action.

NEW SECTION. **Section 33. Waiver of certain laws.** A law that requires the inclusion of a specific category of licensed health care practitioner does not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36].

NEW SECTION. **Section 34. Administrative procedure.** The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and administer [sections 22 through 36].

NEW SECTION. **Section 35. Standards to ensure fair marketing.** (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage other than the basic or standard health benefit plans to a

small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly,

enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce

or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

NEW SECTION. Section 36. Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after [the

1 effective date of this section], to reissue a health benefit
 2 plan to any small employer whose health benefit plan has
 3 been terminated or not renewed by the carrier after [6
 4 months prior to the effective date of this section]. The
 5 commissioner may prescribe the terms for the reissuance of
 6 coverage that the commissioner finds are reasonable and
 7 necessary to provide continuity of coverage to small
 8 employers.

9 NEW SECTION. **Section 37.** Codification instructions.
 10 (1) [Sections 1 through 20] are intended to be codified as
 11 an integral part of Title 50, and the provisions of Title 50
 12 apply to [sections 1 through 20].

13 (2) [Sections 22 through 36] are intended to be
 14 codified as an integral part of Title 33, and the provisions
 15 of Title 33 apply to [sections 22 through 36].

16 NEW SECTION. **Section 38.** Effective dates. (1)
 17 [Sections 1 through 20, 37, and this section] are effective
 18 on passage and approval.

19 (2) [Section 21] is effective July 1, 1996.

20 (3) [Sections 22 through 36] are effective January 1,
 21 1994.

-End-

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STATE OF MONTANA - FISCAL NOTE

Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0285, third reading.

DESCRIPTION OF PROPOSED LEGISLATION: An act providing for universal health care access, health care planning and cost containment; creating the Montana Health Care Authority, providing for the powers and duties of the authority; requiring a statewide universal health care access plan; requiring a health care resource management plan; providing for simplification of health care expenses billing; requiring the authority to conduct a study and report on long-term care; requiring the authority to establish health planning regions and boards; providing for the powers and duties of regional boards; requiring the establishment of a unified health care data base; providing for health insurance reform; and transferring to the authority certain functions of the department and board of health and environmental sciences relating to vital statistics.

ASSUMPTIONS:Montana Health Care Authority

1. During the 1995 biennium, the Montana Health Care Authority (MHCA) will focus predominately on development of a health care database, analysis of patterns of health care utilization and cost, policy development, and development of specific health plans for presentation to the 1995 legislative session.
2. Development of the organization structure necessary to fulfill the responsibilities of the MHCA will occur as soon as possible after passage of the bill. The executive director and board secretary will be hired as soon as possible upon passage.
3. Due to the complexity of health care issues, the MHCA will require significant technical assistance on a wide variety of issues impacting the different sectors of health care including the general field of medicine, health care reform, legal ramifications of medical malpractice issues, substantial actuarial data collection and analysis, medical technology, and complex health data system. In order to give the MHCA the flexibility to analyze the staffing needs of the Authority and identify those services that could most efficiently be provided through contracts, the majority of funds are allocated to operating expenses with the understanding that the MHCA would have the option to hire such staff as deemed necessary and appropriate.
4. The five appointed members of the Health Care Authority serve as volunteers and are not state employees.
5. There will be five regional boards. All regional board members are volunteers and are not state employees.
6. The MHCA and regional boards will conduct at least six meetings per year during the first two years.
7. Travel and per diem for regional boards is included in the operating expenses of the MHCA.
8. It is anticipated that grant funds from the Robert Wood Johnson Foundation will be available to assist the MHCA in the development of the statewide health care database.
9. To the extent that MHCA activities are directly related to the state's Medicaid program, such expenditures could be matched for federal funds at a ratio of 50% state and 50% federal funds.
10. The Vital Statistics Bureau will be transferred intact to the Health Care Authority. Existing bureau expenditures and revenues will remain, but are not included in this fiscal note. If the Vital Statistics Bureau were physically moved there would be costs related to that move we are unable to estimate.

(Continued)

Dave Lewis 3-10-93
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Eve Franklin 3/13/93
EVE FRANKLIN, PRIMARY SPONSOR DATE
Fiscal Note for SB0285, third reading

SB 285.42

(continued)

State Auditor's Office

11. The insurance commissioner will appoint a nine member Health Benefit Plan Committee July 1, 1993. They will conduct meetings and recommend a basic and standard plan by Dec 31, 1993. The commissioner will adopt plans by March 1, 1994.
12. The insurance commissioner will receive the required premium information from insurance companies by Sept 1, 1993 and will appoint a nine member reinsurance board by Sept 15, 1993. This board will submit an operational plan for reinsurance by March 15, 1994. The commissioner will adopt the plan by May 15, 1994.
13. The commissioner will adopt rules for rating practices and actuarial certification during FY94.
14. The commissioner will work with the Authority to design a uniform claim form (Section 10) and will adopt rules in FY95 to implement the form. Implementation will not occur during the 95 biennium.
15. The reinsurance plan will take effect July 1, 1994. The board will use its authority to borrow funds for initial operations and to cover claims. Assessments will be made against premiums in an amount necessary to pay off the loan. Therefore no general fund appropriation will be necessary to cover a loss or loan payment.

FISCAL IMPACT:

<u>Montana Health Care Authority</u>	<u>FY '94</u>			<u>FY '95</u>		
	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>
FTE	0	2.00	2.00	0	2.00	2.00
Personal services	0	93,921	93,921	0	93,921	93,921
Operating expenses	0	656,079	656,079	0	656,079	656,079
Total	0	750,000	750,000	0	750,000	750,000

Funding:

General Fund*	0	750,000	750,000	0	750,000	750,000
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* Ignores potential use of federal and foundation funds per assumptions 8 and 9.

<u>State Auditor's Office</u>	<u>FY '94</u>			<u>FY '95</u>		
	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>
FTE	0	2.00	2.00	0	2.00	2.00
Personal Services	0	107,217	107,217	0	107,217	107,217
Operating Costs	0	68,600	68,600	0	56,600	56,600
Equipment	0	2,568	2,568	0	0	0
Total	0	178,385	178,385	0	163,817	163,817

Funding:

General Fund	0	178,385	178,385	0	163,817	163,817
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TECHNICAL NOTES:

The effective date of sections 22-36 should be July 1, 1993 in order to meet other deadlines in the bill.

The reinsurance board needs statutory appropriation authority as provided in Section 17-7-502, M.C.A. in order to pay claims anticipated by creation of the reinsurance pool.

SB 285 #2

COMMITTEE--HOUSE HUMAN SERVICES & AGING

Page 6

BILL NO - REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE ----- REREFERRED ----- DATE READ

SB0209	CRIPPEN, BRUCE	1/30	2/05	REVISE OPTOMETRIST LICENSURE, TESTING, CONTINUING EDUCATION, BOARD MEETINGS	CONCUR AS AMENDED 2/10	VOTE: 16-0	2/11
SB0271	JACOBSON, JUDY	3/22	4/02	ESTABLISH LOCAL CITIZEN REVIEW BOARD FOR FOSTER CARE PLACEMENTS	CONCUR AS AMENDED 4/12	VOTE: 12-0	4/14
SB0285	FRANKLIN, EVE	2/23	3/24	CREATE MONTANA HEALTH CARE AUTHORITY	CONCUR AS AMENDED 3/29	VOTE: 15-0	3/30
SB0291	DOHERTY, STEVE	2/23	3/08	REVISE UTILIZATION REVIEW OF OUTPATIENT MENTAL HEALTH TREATMENT NOTES	CONCUR 3/12	VOTE: 16-0	3/13
SB0312	BECK, TOM	2/23	3/03	AMEND FAMILY PRACTICE TRAINING ACT TO ALLOW LONGER COMMUNITY TRAINING	CONCUR 3/5	VOTE: 16-0	3/08
SB0313	TOWE, TOM	2/23	3/03	REVISE ADULT FAMILY CARE STATUTES	CONCUR AS AMENDED 3/12	VOTE: 16-0	3/13
SB0314	CHRISTIAENS, CHRIS	3/22		REQUIRE EACH SUBDIVISION OF ISSUER TO PAY PORTFOLIO REGISTRATION FEE	VOTE:	BUSINESS & LABOR	
SB0403	RYE, DAVID	2/23	3/08	CLARIFY DEFINITION OF OUTPATIENT FACILITIES IN HEALTH CARE LICENSING LAWS	CONCUR AS AMENDED 3/12	VOTE: 9-7	3/13
SJ0011	WILSON, WILLIAM	2/10	3/03	URGE REGULATION OF PRICING OF PRESCRIPTION DRUGS	CONCUR 3/12	VOTE: 15-1	3/13

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By CHAIRMAN BILL BOHARSKI, on March 24, 1993, at
3:00 p.m.

ROLL CALL

Members Present:

Rep. Bill Boharski, Chairman (R)
Rep. Bruce Simon, Vice Chairman (R)
Rep. Stella Jean Hansen, Vice Chair (D)
Rep. Beverly Barnhart (D)
Rep. Ellen Bergman (R)
Rep. John Bohlinger (R)
Rep. Tim Dowell (D)
Rep. Duane Grimes (R)
Rep. Brad Molnar (R)
Rep. Tom Nelson (R)
Rep. Sheila Rice (D)
Rep. Angela Russell (D)
Rep. Tim Sayles (R)
Rep. Liz Smith (R)
Rep. Carolyn Squires (D)
Rep. Bill Strizich (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Alyce Rice, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 508, SB 285
Executive Action: None

Other Committee Business:

CHAIRMAN BOHARSKI said HB 508 has been amended into SB 285 in its
entirety. Both bills will be heard at the same time. REP. FAGG
will open on HB 508; then SEN. FRANKLIN will open on SB 285.

HEARING ON HB 508 and SB 285Opening Statement by Sponsor of HB 508:

REP. RUSSELL FAGG, House District 89, Billings, said health care is the issue for the 1990's. SEN. FRANKLIN has an excellent bill. Both bills will need some amendments. REP. FAGG waived his closing statements.

Opening Statement by Sponsor of SB 285:

SEN. EVE FRANKLIN, Senate District 17, Great Falls, said she is not representing any special interest group for SB 285. SB 285 was instigated by citizens who struggle with access to health care and its cost. The bill provides for universal health care access, health care planning, and cost containment. It sets up an infrastructure, which is called the Montana Health Care authority. This authority is non-partisan, which gives the House and Senate majority and minority leaders the ability to choose individuals with expertise in health care, legislators, and other community members for input. The names will be submitted to the Governor, from which he will choose five, to serve on the health care authority. Five health care planning regions will be set up. There needs to be policy that establishes access for people to services basic to their health care needs. Cost containment is probably the most critical issue. The goal is to not exceed the average annual percentage increase in the gross domestic product by 1999. Health care is not cheap. The focus will be on limiting the degree of escalation.

Proponents' Testimony:

Lieutenant Governor Dennis Rehberg said an old anecdote says that people support reform as long as it doesn't change anything. SB 285 does change things. Lieutenant Governor Rehberg said when he was newly appointed he traveled to all 56 counties. Health care was the number one issue. There is no greater fear among people in rural communities than not having access to health care, and affordable health care. SB 285 addresses 60 to 70 percent of the issues raised through the Health Care for Montanans project over the last few years. SB 285 is a good bill and has the support of the Governor's office.

Mark O'Keefe, State Auditor, Commissioner of Insurance and Securities, said although the insurance reform portion may not be exactly what he would like to see in the bill, it is a step in the right direction, and he supports it. Mr. O'Keefe reviewed the insurance portion of the bill.

Dr. Peter Blouke, Director, Department of Social and Rehabilitation Services, said health care reform touches everyone's lives. Montana's Medicaid system is part of the state's overall health care system. It is subject to the same

inflationary crisis as other components of the health care system. As Medicaid expenditures continue to grow at the same inflationary rate as experienced during the 1993 and 1995 biennium, by FY 1996-1997, Medicaid will require an additional \$66,000,000 from the general fund. To put that amount into perspective, \$66,000,000 represents the entire general fund budget for Montana State University and the University of Montana combined. The additional \$66,000,000 in general fund money is enough to fund the entire biennium budget of 25 state agencies. Montana must design health care reform for Montanans. SB 285 is not a perfect bill, but it represents a good compromise. It is an important first step toward health care reform. Dr. Blouke urged the committee to support SB 285.

REP. JIM RICE, House District 43, Helena, said there are problems with our health care system that need to be addressed. Government does have a proper role in regulating health care. Skyrocketing medical costs are bankrupting our state budget, affecting such programs as workers' compensation and social services. As the cost of health care and health insurance increases, many businesses and individuals are unable to afford it. Consumers are not making medical decisions based upon the economics of supply and demand as they do in their other decision making. The medical market place is not conducive to the making of informed economically based decisions. SB 285 presents an ambitious start in health care reform that we need to make now.

Dave Forbes, Pharmacist. Written testimony. EXHIBIT 1.

Teresa Henry, Registered Nurse, presented written testimony from Kathleen Long, PhD, RNCS, FAAN. EXHIBIT 2.

John Cadby, Montana Bankers' Association, presented amendments to SB 285 and HB 508 changing the definition of "small employer" to include small banks. EXHIBITS 3, 4, and 5.

Lawrence White, President, St. Patrick's Hospital, Missoula, supports SB 285.

Jeff Strickler, MD, Helena Pediatric Clinic, Helena. Written testimony. EXHIBIT 6.

Jim Ahrens, President, Montana Hospital Association, said the association is in full support of SB 285. Mr. Ahrens presented and reviewed amendments to SB 285. EXHIBIT 7.

Bill Leary, President, Montana Coalition on Health Care Cost Containment, read excerpts from the Report of the Health Care Cost Containment Advisory Council. EXHIBIT 8.

Steve Turkiewicz, Secretary, MADA, Insurance Trust, Board Member, Montana Association of Health Care Purchasers, supported SB 285 and the amendments presented by John Cadby.

Wally Henkelman, Registered Nurse, Member, Montana Nurses' Association. Written testimony. EXHIBIT 9.

Bill Olson, American Association of Retired Persons. Written testimony. EXHIBIT 10.

Christine Mangiantini, League of Women Voters. Written testimony. EXHIBIT 11.

Dr. John Gregory, Past President, Montana Medical Association (MMA), supported SB 285. Dr. Gregory presented amendments to SB 285, which he said would restore the bill to its original intent. EXHIBIT 12.

Larry Akey, Montana Association of Life Underwriters, said section 27, subsection 1, (j), regarding age rating, should be stricken. The association believes the social function for insurance is the accurate pricing of risk. If the only case characteristics insurance companies can look at is age, the social function of health insurance will be wiped out. The insurance provisions are intended to address the issue of access. The provisions in the bill do not address the issue of affordability of health insurance. If this section is adopted without sufficient cost containment measures, the cost of health insurance will increase, not decrease. The insurance provisions in HB 508 and SB 285 only address the access issue, not the affordability issue. The association believes that SB 285 is a significant step in the right direction.

Tanya Ask, Blue Cross and Blue Shield of Montana. Written testimony. EXHIBIT 13.

Tom Hopgood, Health Insurance Association of America, said the association supports SB 285.

Elizabeth Dane, Montana Chapter of the National Association of Social Workers, read testimony from Susan Swinehart, Social Worker on behalf of the Montana Mental Health Providers Coalition. EXHIBIT 14.

Suzy Holt, Montana Task Force for Biomedical Information, presented the task force's report to the Governor. EXHIBIT 15.

Verner Bertelsen, Montana Legacy Legislature. Written testimony. EXHIBIT 16.

David Owen, Montana Chamber of Commerce (MCC) supported SB 285.

Jamie Doggett, Montana Cattlewomen, supported SB 285.

Mary McCue, Montana Clinical Mental Health Counselors' Association supported SB 285.

Doug Campbell, President, Montana Senior Citizens' Association.

Written testimony. EXHIBIT 17.

Lloyd Anderson, Montana Senior Citizens' Association, supported SB 285.

Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health, supported SB 285.

Dale Pfau, Vice President and General Manager, Don's Inc. Written testimony. EXHIBIT 18.

Ted Lange, Northern Plains Resource Council, Big Muddy Resource Council said health care reform is of tremendous importance in Montana's rural communities. Mr. Lange urged the committee to support SB 285.

Clyde Dailey, Executive Director of the Montana Senior Citizens Association, Chairman, Montanans for Universal Health Care Coalition. Written testimony. EXHIBIT 19.

Christian Mackay, Montanans for Universal Health Care. Written testimony. EXHIBIT 20.

John Shontz, Mental Health Association of Montana, supported SB 285.

Chet Kinsey, Montana Senior Citizen's Association, supported SB 285.

Don Judge, Montana State AFL-CIO, supported SB 285.

Dr. Robert J. Ardis, MD, Great Falls. Written testimony. EXHIBIT 21.

Lloyd Anderson, Montana Senior Citizen's Association, supported SB 285.

Sharon Hoff, Montana Catholic Conference. Written testimony. EXHIBIT 22.

Dan Edwards, International Representative, Oil, Chemical & Atomic Workers International Union, AFL-CIO. Written testimony. EXHIBIT 23.

Michael Regnier, Advocacy Coordinator, Summit Independent Living Center; Vice President, Coalition of Montanans Concerned with Disabilities, Missoula. Written testimony. EXHIBIT 24.

Elmer Kobold, MD, Great Falls. Written testimony. EXHIBIT 25.

John Bartos, Administrator, Marcus Daly Memorial Hospital, Hamilton. Written testimony. EXHIBIT 26.

William A. Reynolds, MD, The Western Montana Clinic, Missoula.

Written testimony. EXHIBIT 27.

Opponents' Testimony:

Mike Schweitzer, Self. Written testimony. EXHIBIT 28.

Jim Fleischmann, Montana People's Action (MPA), said MPA supports SB 285, but cannot support the insurance reform provisions. Representatives of the industry have proposed that a certain section of SB 285 be eliminated, which would allow unlimited use of case characteristics in health status. If this is allowed, the industry will continue to medically underwrite people and place them wherever they want on the huge spectrum being created. Medical underwriting will likely be increased, as it has in other states. The insurance industry understands the system they control. The industry can place people any place on the spectrum, from the lowest rate to the highest, and deny them for practically any reason they choose. The section that limits case characteristics to age must be maintained. SB 285 does not allow any circumvention of the state's mandated health benefits; HB 508 does. The insurance industry claims that mandated benefits are the primary force that drive up the cost of insurance. Mandated benefits at their worst, might add 20% to the cost of the insurance premium according to studies across the nation. Other states that reduced or eliminated mandated benefits have had terrible experiences because of high deductibles and limited lifetime benefits. There is no reason to undo years of legislative activity, which firmly establishes mandated benefits as a basic protection which the people of this state should have in their insurance policies.

Paul Gorsuch, MD, Great Falls. Written testimony. EXHIBIT 29.

Dale Schaefer, MD, Great Falls, supports health care reform and the general concepts of SB 285, but cannot support the bill as written because it does not allow for alternatives.

Allyn Christiaens, Montana People's Action, supports most of SB 285, but the insurance portions of the bill are blatantly unacceptable.

Tamy VanderAarde, MD, opposed SB 285.

Dan Shea, Montana Low Income Coalition, said the health care authority is being given an impossible task. Cost control must be placed on doctors; otherwise the sky is the limit. Mr. Shea said a lawyer told him when Dr. Gorsuch appears in court to give a deposition, he charges a fee of \$1,000 an hour. Some people working in the health care industry, who are the very backbone of the medical system don't make \$1,000 in a month. Mr. Shea disputed testimony that there is about an eight to one advantage in Medicaid because for every \$1 Montana spends, the federal government pays \$8. Mr. Shea said for every \$1 Montana pays in Medicaid, which will be close to \$75,000,000 this year, the

federal government pays approximately \$2. The problem with Medicaid is that the doctors, hospitals, and nursing homes have preferential treatment from Medicaid because there are laws in Washington D. C. that allow them to inflate their costs at will. Social and Rehabilitation Services (SRS) wants caps on attorneys' fees in malpractice cases. SRS has not asked for caps on doctors' fees. That is where the problem lies. Mr. Shea suggested the previous Director of SRS, recommended huge increases for medical providers. The director was married to a medical doctor. That is conflict of interest. SRS is part of the problem. St. Peter's Hospital had to lay off people because it overexpanded its physical capacity. If the hospital had been required to obtain a certificate of need to build, there is a strong likelihood it would not have built, and all those employees would not have been laid off. This legislature can still enact legislation reenacting the certificate of need. Mr. Shea referred to page 26, section 16, subsection (a), of SB 285, regarding the feasibility of maintaining exemptions from the certificate of need process, and said hospitals should be added to the list.

CHAIRMAN BOHARSKI warned the testifiers that personal comments made about the former Director of SRS and people in the audience were out of bounds. In the future, if anyone speaks in such a manner he will stop them.

Tim Mendenhall, MD, Great Falls, opposed SB 285.

Paul Peterson, Consumer, opposed SB 285.

Bonnie Tippy, Montana Chiropractic Association, opposed SB 285.

Informational Testimony:

None

Questions From Committee Members and Responses:

REP. NELSON referred to Jim Fleischmann's statement that the insurance industry claims mandated benefits are the primary factor in premiums going up. REP. NELSON asked Mr. Fleischmann if claims really drive up premiums. Mr. Fleischmann said claims do cause premiums to rise.

REP. SIMON said he didn't see anything in the bill regarding consumer education, which is an important link in cost control. REP. SIMON asked SEN. FRANKLIN if that could be added to section 1 of the bill, to which she agreed.

CHAIRMAN BOHARSKI referred to an earlier question about moving from Medicaid or Medicare to the new small group employment plan and losing pre-existing condition coverage. He asked Ms. Ask if subsection b, lines 13 through 23 covered that situation. Ms. Ask said there is a definition of qualifying previous coverage on

page 41 of the bill. If someone was previously covered under Medicare or Medicaid and moved to a small group employment plan within 30 days, he/she will be covered.

REP. BOHLINGER asked Clyde Dailey why hospitals aren't listed in section 16, page 26, regarding the consideration of maintaining exemptions from the certificate of need process. Mr. Dailey said that section is important just to maintain the ability for the commission to look at the certificate of need. Although hospitals are exempted, they are defined within the certificate of need. Mr. Dailey said hospitals could be added to the list but wasn't sure that was necessary.

REP. SMITH asked Dr. Gorsuch how the unified health plan would be transferable to other states. Dr. Gorsuch said reciprocity would be negotiated with other states. SEN. FRANKLIN added, for example, currently Blue Cross and Blue Shield of Montana would pay Montana rates if a BCBS consumer from Montana was visiting Washington and needed medical services.

CHAIRMAN BOHARSKI asked SEN. FRANKLIN if the Senate had discussed giving the nine-member commission the discretion to study the need for mandated benefits. SEN. FRANKLIN said it had not been discussed in the Senate committee but has been discussed with different groups in the industry and people's action groups.

CHAIRMAN BOHARSKI said a conservative estimate of the cost of mandated benefits would be about 10% to 12%. Taking that into consideration, the bill would raise the costs approximately 10%; therefore, he thought it would be a good idea for the commission to review the need for mandated benefits. The NAIC model bill did not have mandated benefits. Now the Senate has taken the position to either take freedom of choice out or leave mandated benefits in. It seems that the commission's hands are tied, trying to come up with a basic plan. Their basic plan is what is already in Montana law. SEN. FRANKLIN referred to earlier testimony that if basic plans are too basic, they are not all that valuable.

REP. SAYLES asked SEN. FRANKLIN about the political makeup of the people on the board. SEN. FRANKLIN said the mechanism needs to be one that finds people who are committed to the content of the discussion, who are not wedded to either politics or personal gain. There are risks involved no matter what choices people make.

Closing by Sponsor:

SEN. FRANKLIN said there is no quick fix. Everyone involved will have to give up something that is probably perceived as very significant to them. SEN. FRANKLIN said she would reserve any further discussion until Friday.

Testimony

ed to the Authority:

rged with drafting a statewide universal health
n based on a single payer system and a
or a statewide universal access plan based on a
e payer system - both plans will be submitted to
o be considered during the 1995 session.

same rate as those serving on state boards and

mploy a fulltime executive director

mploy professional and support staff

ased upon regions comprised of counties already
he Department of Health and Environmental Sciences.

ing Boards - one for each region. Each county will
tative on the regional board for the region in which
located.

Regional Board Membership - will be done by the

ional Boards - advise the Authority, funded by grants
ority, will draft a health resource plan for the
be involved in consumer education.

collection. If appropriate planning and cost
asures are going to become reality, then appropriate
be collected. Various state agencies collect data but
data often are not shared with other programs.

various programs and various health care providers
using different formats. A central authority needs to
ple for all data collection so that appropriate
n be made. Finally, all parties - providers and
well - need appropriate data upon which to base their

all payer system. This is a confusing term but as I
it, it essentially means that all payers i.e. private
- must pay the same rate for similar health care
ndered. This real issue here is "cost shifting" which
rovided for equitable reimbursement to health care

In other words, too often hospitals and other health
ers have to subsidize, for example, Medicaid patients,
g either private pay or privately insured individuals
ler to break even and/or stay in business. I have heard
al CEO state that he believed his hospital could charge
less for services rendered to privately insured patients
programs would pay actual cost.

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EXHIBIT 1
DATE 3/24/93
SB 285

Page Three: Forbes' Testimony

Finally, a few additional thoughts. Some people will ask for a market based medical system as an option. There is, in my opinion, no such system. But, more importantly, the United States has tried to allow a health care market system to function. However, health care information or knowledge is far too complex to allow for a market based system to function. Especially so when the end user i.e. the patient, does not, in most cases, pay for the services provided. It is not like buying a car or groceries at the market. As I see it, the bottom is this - whether health care professionals are paid via fee for service or salary, the concept of a "professional person" is such that the needs of a client (patient) are placed above those of the person providing the service.

Thank you for the opportunity to share my views with respect to SB 285.

HEALTH CARE

There must be a remedy for this diseased system

By DAVE FORBES

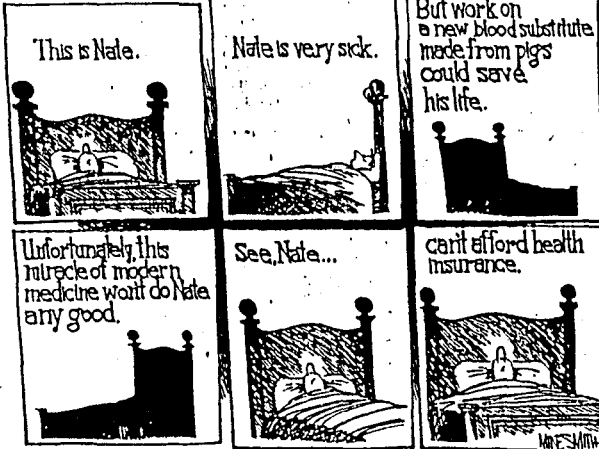
Who is to blame for the shortcomings of the U.S. health-care system? People often point the finger of blame at the government and lawyers. But the facts simply don't support blaming those sectors of society for the imperfections of the health-care system.

With respect to the government, the Medicare program commenced in 1966 as a basic health insurance program for the elderly. Before then many elderly went without adequate health care. While many health care professionals opposed this federal plan as socialized medicine, most knowledgeable people would agree that this program was needed and has been quite soundly managed.

With respect to lawyers, it is my belief that the court system through malpractice suits has done more to upgrade standards of the health-care professions than have professional societies or the professions themselves. Everyone wants his own lawyer to be meaner than a junkyard dog but the other guy's lawyer should be afraid to sue.

What of the U.S. health-care system? Are there better systems present in other countries? Maybe. Is our system, on balance, serving society as we might expect? Maybe and maybe not. Remember the phrase — "It depends on whose ox is being gored"?

Most of us do not know or even have any idea of the cost of various health-care procedures. Why? Because we do not pay for these procedures, at least not out of our own pockets. One of the most clever strategies ever put in place by any industry was the creation of the third-party pay system (health insurance) with the consumer and the provider being the first and second parties and the fiscal intermediary (which processes the claims) being the third party. Also, keep in mind that most of us would generally consider insurance as protection from unforeseen circumstances, such as fire and auto damage. However, you can be quite certain that you will be in need of medical care sometime during your lifetime. So it



really not insurance but a system of payment of society's health care expenditures (that is, except for the approximately 37 million Americans who have no health insurance). Also, we don't pay taxes on these benefits, as we do for our salaries or wages.

Who ultimately pays for health care? You and I do, of course, but most of us do not need to budget much, if any, of our disposable income for health care like we do for housing, food, clothing, education, transportation, etc.. If you work for state government, like I do, then taxpayers pay the monthly health insurance premiums. If you work in the private sector and if you are fortunate enough to work for an employer who provides you with health insurance as a fringe benefit, then the consumers who buy your goods or services pay for your health insurance premiums as part of the purchase price of those goods and services.

I have no quarrel with the health insurance industry but I do refer to the present system as "the anesthetic on our pocketbooks." That is to say that if you and I do not directly pay for our medical care, then do we care about the level of prices charged for these medical care services? The answer in both cases is we do not.

If value is received by health-care consumers for medical services rendered then why should we be alarmed if health-care expenditures are approximately 12 percent of our gross national product? No good reason as far as I can see.

It is not the health-care system's fault that we have a large federal deficit or that the savings and loan industry bailout will cost us billions or that Saddam Hussein is a lunatic.

I was born in the mid-'40s, and when I was a youngster polio was feared by my parents. Medical care was inexpensive but there was not much medical care available to purchase. Since then our society has spent billions on research and to state that there is now much more medical care available than there was years ago is one of the great understatements of all time. New technology costs money, lots of money, and of course, all of us want the best for ourselves and our families.

What is the answer? I do not know. Funerals are cheap compared to health care. Do we want to turn the clock back to where the physician spent much of his or her time consoling patients because there was little medical care available? Years ago people died at younger ages and it appeared to be at a lesser cost to society.

I doubt that we want to turn the clock back to those times. It seems to me that if we can find money to bail out the savings and loan industry and to successfully fight Desert Storm then we can find ways to work together as consumers, providers, federal and state governments and the health insurance industry in order to provide health care to all our citizens.

Dave Forbes is dean of the School of Pharmacy & Allied Health Sciences at the University of Montana.

EXHIBIT 1
DATE 3/24/93
SB 285

Testimony of Kathleen Ann Long, PhD, RNCS, FAAN
presented by Theresa Henry, MS, RN

HEALTHMONTANA HEARING BEFORE THE HUMAN SERVICES AND AGING
COMMITTEE OF THE MONTANA HOUSE OF REPRESENTATIVES

March 24, 1993

Honorable Committee Members:

I am Teresa Henry and I am presenting testimony on behalf of Kathleen Long, who is unable to be present. Dr. Long is a registered nurse, certified for advanced practice nursing. For the past 12 years, she has been involved in direct patient care and nursing education in Montana. She served as a co-chair of the Citizen's Committee which assisted in drafting the HealthMontana legislation.

Her testimony is as follows:

I would like to speak to you about the cost containment aspects of the bill. The following background facts may be helpful to you as you consider the cost containment issue.

- ▶ In October, 1992, the Congressional Budget Office reported that lack of restraint in the health care industry, unless changed, will cost this nation \$1.7 trillion by the year 2000.

In 1965, health care costs consumed 6% of our Gross Domestic Product; that percent grew to 12 in 1990 and is projected to be 18% by the year 2000.

- ▶ If uncontrolled, national health care costs are anticipated to increase by \$500 billion between 1990 and 1995, and this will occur while over 60 million Americans are without adequate health care (National Leadership Coalition for Health Care Reform) -- a situation which ultimately results in tremendous social costs due to lost productivity and eventual reliance on social welfare programs.
- ▶ Despite these enormous expenditures, we do not have an enormously successful health care system. It is true that millions of persons receive highly sophisticated, technologically advanced health care. However, our health care is not fairly or equitably delivered; a fact which is readily apparent in many areas of Montana.
 - In a recent comparison with ten other developed nations, the United States ranked last in the delivery of primary health care -- that is health promotion, disease prevention and early intervention -- precisely the type of health care that is most cost-effective (National League for Nursing, 1991).
 - Many diseases once thought eradicated, such as tuberculosis and measles, are now reaching epidemic proportions.

I expect that what is of most interest to you are facts which are specific to Montana.

- Over the last 10 years, the average Montana family's spending on health care rose 382% faster than wages.
- Business spending for health insurance coverage rose by more than 280%.
- Medicaid spending has become the fastest growing sector of Montana's budget, now consuming over 15% of the general fund.
- Despite these expenditure increases, over 100,000 Montanans are not covered by any type of health care program.

Clearly, something is very wrong with the status quo.

Cost containment tends to be a distasteful aspect of any bill. It conjures up notions of governmental interference. It is certain to be opposed by those whose incomes may be affected.

Nevertheless, I believe the facts speak for themselves. Cost containment is an essential part of any health care reform bill. The HealthMontana bill offers a rational, phased-in approach to cost containment. It provides for a five year period of adjustment to bring costs into line with the Gross Domestic Product, and allows for consideration of factors such as population increase and unanticipated provider costs. The bill specifically addresses advance budget planning to prevent precipitous closures of health care facilities or loss of health care services. The cost containment measures proposed in the HealthMontana bill, including the global budgeting provisions, have been extensively studied at the national level, and have been found to be appropriate and effective. Global budgeting is necessary for cost containment. Reimbursement based on the service provided, rather than the discipline of the provider ensures cost-effective delivery of health care.

In summary, HealthMontana's cost containment provisions require us to live within our means while improving access to the most cost-effective forms of health care.

Each constituency involved in health care -- consumers, payers, and providers -- will be required to make compromises if we are to reform and improve health care delivery in Montana, and ultimately throughout this nation. As you weigh this difficult matter, I trust in your ability to discern vested interests. Those who oppose health care reform, including cost containment, should bear the burden of justifying the outrageous costs and inadequate service in our current system.

Health care reform in Montana is both an ethical imperative and an economic necessity. The HealthMontana bill is a comprehensive, well-reasoned approach to such reform.

Thank you for allowing me the opportunity to speak, and for your work on this critically important issue.

PROPOSED AMENDMENTS TO
SENATE BILL 285

AMEND SECOND READING BILL, Section 24,
subsection (24), page 42 of bill, lines 7-16 as follows:

(24) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation, or that are members of an association that has been in existence for one year prior to (the effective date of this act) and that provides a health benefit plan to the employees of its members as a group, are considered one employer.

PARTICIPATING BANKS IN MONTANA

United Bank, Absarokee
Bank of Baker, Baker
Belt Valley Bank, Belt
Big Sky Western Bank, Big Sky
Citizens Bank & Trust, Big Timber
First Boulder Valley Bank, Boulder
First Citizens Bank, Bozeman
Blackfeet National Bank, Browning
First Citizens Bank, Butte
Stockmens Bank, Cascade
Western Bank, Chinook
Citizens Bank, Choteau
First Security Bank, Deer Lodge
Farmers State Bank, Denton
State Bank & Trust Co., Dillon
Dutton State Bank, Dutton
First National Bank Ekalaka
First Madison Valley Bank, Ennis
First National Bank, Fairfield
First State Bank, Froid
First National Bank, Geraldine
First Fidelity Bank, Glendive
Citizens State Bank, Hamilton
Little Horn State Bank, Hardin
Continental National Bank, Harlowton
First National Bank, Hinsdale
First National Bank, Hysham
First Security Bank, Laurel
First National Park Bank, Livingston
First State Bank, Malta
Manhattan State Bank, Manhattan
Flint Creek Valley Bank, Philipsburg
Montana National Bank, Plentywood
First Citizens Bank, Polson
Traders State Bank, Poplar
U.S. National Bank, Red Lodge
Richey National Bank, Richey
First Security Bank, Roundup
Lake County Bank, St. Ignatius
Citizens State Bank, Scobey
First Valley Bank, Seeley Lake
First United Bank, Sidney
State Bank, Townsend
Ruby Valley National Bank, Twin Bridges
First National Bank, White Sulphur Springs
Western National Bank, Wolf Point
Farmers State Bank, Worden

PARTICIPATING BANKS IN WYOMING

Frontier Bank, Cheyenne
Western Bank, Cheyenne
Converse County Bank, Douglas
Dubois National Bank, Dubois
State Bank, Green River
Bank of Laramie, Laramie
Riverton State Bank, Riverton
First State Bank, Thermopolis

REPORT NO. DIHC510H

LIMITED LIABILITY GROUP PAID BASIS REPORT FOR
GLUG 02M60EXHIBIT 2
DATE 3/24/93
SP 285PAGE NO. 4,037
RUN DATE: FEB 05 93POLICY NO. 24-02M60 ST BANKERS ASSOC GRP OF
1 N LAST CHANCE GULCHREPORT SEQUENCED BY: POLICY NO., EXP COMB CODE, SERVICE OFFICE
FROM 2/91 THRU 1/93
PAGE 1 OF 1

POLICY NO. 24-02M60

HELENA MT 59601

REG SERVICE OFFICE	COMB CODE	PRODUCT	RISK	FUNDING METHOD	SPECIAL LINES	EFFECTIVE DATE	CANCEL DATE	RATE RENEWAL DATE
MINNEAPOLIS	0225	HEALTH/MEDICAL	RETEN	LIM LIAB		1/01/90		10/01/92

----- H E A L T H A N D A C C I D E N T -----

DATE	ENROLLMENT COUNT	MEDICAL PREMIUM	+	DEPOSIT	=	TOTAL FUNDS	PAID CLAIMS		TOTAL CLAIMS	DRAFT COUNT	MEDICAL CLAIM		AD & U PREMIUM	CLAIMS
							FROM DEPOSIT FUNDS	FROM INS. CO. FUNDS			RATIO	PREMIUM		
02/91	789	150,550		0		150,550	0	96,254	96,254	344	63.9		0	0
03/91	783	148,654		0		148,654	0	77,335	77,335	253	52.0		0	0
04/91	785	149,921		0		149,921	0	104,679	104,679	374	69.8		0	0
05/91	780	147,672		0		147,672	0	95,582	95,582	340	64.7		0	0
06/91	773	147,757		0		147,757	0	62,936	62,936	345	42.6		0	0
07/91	774	147,756		0		147,756	0	88,882	88,882	420	60.2		0	0
08/91	779	147,945		0		147,945	0	95,399	95,399	419	64.5		0	0
09/91	773	148,025		0		148,025	0	91,348	91,348	345	61.7		0	0
10/91	785	150,342		0		150,342	0	128,780	128,780	501	85.7		0	0
11/91	785	148,044		0		148,044	0	144,025	144,025	464	97.3		0	0
12/91	788	149,045		0		149,045	0	134,359	134,359	486	90.1		0	0
SUB TOTAL	781A	1,635,711		0		1,635,711	0	1,119,579	1,119,579	4,291	68.4		0	0
MEMO ITEM		110,059 TD												
01/92	787	152,972		0		152,972	0	91,648	91,648	491	59.9		0	0
02/92	819	22,409		130,839		153,248	101,632	46,277	147,909	445	96.5		0	0
03/92	783	20,219		123,398		143,617	183,117	12,802	195,919	344	136.4		0	0
04/92	774	21,400		126,831		148,231	144,641	40,665	185,306	413	125.0		0	0
05/92	745	20,625		122,434		143,059	45,419	33-	45,386	361	31.7		0	0
06/92	746	20,659		122,548		143,207	131,556	1,015-	130,541	373	91.2		0	0
07/92	716	20,173		120,152		140,325	118,554	0	118,554	448	84.5		0	0
08/92	735	20,336		120,831		141,167	187,490	104-	187,386	354	132.7		0	0
09/92	716	20,173		120,152		140,325	83,135	0	83,135	293	59.2		0	0
10/92	716	20,173		120,152		140,325	93,222	24,643	117,865	590	84.0		0	0
11/92	734	20,463		121,821		142,284	101,250	3,026	104,276	465	73.3		0	0
12/92	731	20,359		120,939		141,298	78,318	4,793	83,111	489	58.8		0	0
SUB TOTAL	750A	379,961		1,350,097		1,730,058	1,268,334	222,702	1,491,036	5,066	86.2		0	0
01/93	731	20,359 *		120,939		141,298	137,676	0	137,676	595	97.4		0	0
SUB TOTAL	731A	20,359		120,939		141,298	137,676	0	137,676	595	97.4		0	0
GRAND TOT	764A	2,036,031		1,471,036		3,507,067	1,406,010	1,342,281	2,748,291	9,952	78.4		0	0

HELENA PEDIATRIC CLINIC

Elizabeth P. Gundersen, M.D.
Jeffrey H. Strickler, M.D.
John A. Reynolds, M.D.
1300 N. Montana Ave.
Helena, Montana 59601
Phone 406/449-5563

DATE 3-24-93
SB 285

24 March 1993

To: Chairman and Members of the House Human Services and Aging Committee

From: Jeffrey H. Strickler, M.D.
past president, Montana Academy of Pediatrics
member, national AAP Council on Government Affairs

Re: S.B. 285

I speak as a member of the Montana Chapter of the American Academy of Pediatrics in support of this bill. The pediatricians have lobbied for many years in Washington, D.C. for universal access to care for all children and pregnant women and for the expansion of preventive health services. We are very pleased with this bill by Sen. Franklin as it incorporates all of the tenets of our effort. For this alone, your children's doctors urge its passage.

However, I am here also to speak to the concept of cost containment and global budgeting. We cannot continue with business as usual. The fiscal realities of our society demand that we establish priorities in the delivery of health care and revise the way we pay for it.

I have supporting letters from other officers in our organization, Dr Dan Harper of Missoula, Dr. Dennis McCarthy of Butte, and Dr. Jim Feist of Bozeman, but let me give you a personal example. I am a member of a four person pediatric group here in Helena and recently finished a review of our year end 1992 business. Last year we recieved 51% of all revenues as cash payments - no Medicaid, not insurance. This is out of pocket expense for parents. Fifty one percent! How are we going to insure proper preventive services and immunizations for our children when so much of the expense falls directly on young parents? How can we say that we have a system that provides access to care when insurance doesn't cover this much of the cost of pediatric care? And, worse, these figures don't reflect the children who never came in to my office because their parents couldn't afford it!

We must restructure the delivery of health care. If we are to have universal access to care and an emphasis on prevention, we cannot have an open checkbook. A global budget is mandatory to establish these new priorities. To do so without a budget is just bad business practice, and would be improper for you as stewards of the taxpayer's dollar.

Please maintain a strong cost- containment and global budget provision as you give SB 285 a do pass recommendation.

DANIEL A. HARPER, M.D.

Pediatrics and Neonatology

2825 Fort Missoula Road

Missoula, MT 59801

Phone 721-0858

EXHIBIT 6
DATE 3/24/93
SB 285

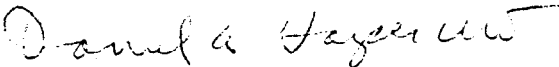
March 19, 1993

Jeffrey Strickler, M.D.
1300 North Montana Avenue
Helena, MT 59601

Dear Dr. Strickler,

I support Senate Bill 285 which is dedicated to improving health care for Montanans. The present situation in Montana is clearly not adequately able to ^{meet} the needs for women and children in particular. I strongly endorse the importance of universal access and strongly endorse the concept of preventative health care for our children. If in order to achieve a reprioritization of our health care dollars global budgeting is necessary, then I would support global budgeting.

Sincerely,



Daniel A. Harper, M.D.

745

Butte Pediatric and Teen Clinic
diseases of children & adolescents
630 west mercury
butte, montana 59701
dennis j. mcCarthy m.d.
linda j. rogers m.d.
cynthia edstrom m.d.
elaine stasny m.d.



EXHIBIT 6
DATE 3/24/93
SB 285

phone - 406-723-4337

March 18, 1993

Jeff Strickler, M.D.
1300 North Montana Avenue
Helena, MT 59601

Dear Jeff:

Pursuant to our phone conversation today, I acknowledge my support of Eve Franklin's Health Bill. To achieve one of the ends of universal access to preventative pediatric care, a global budget with obvious cost constraints on the other end must be considered. I am, thus, also in support of this part of the package.

If you or any of the legislators have specific questions they would like to direct to me, please do not hesitate to call or write.

Yours truly,

Dennis J. McCarthy, M.D.

Dennis J. McCarthy, M.D.

DJM/rb

MHA Antitrust Amendments

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Sen. Towe
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 23, 1993

1. Title.
Page 2, line 9
Following: "ACT;"
Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO
COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF
THE AUTHORITY;"
2. Page 6.
Following: line 5
Insert: "(6) A statement of intent is also required for this
bill because [section 44] requires the authority to adopt
rules implementing [sections 37 through 44]. The rules
adopted by the authority must specify the form and content
of applications for certificates of public advantage;
details of the reconsideration, revocation, hearing, and
appeal processes; and such other matters as the authority
determines necessary. The rules adopted by the authority
must also provide the authority with direct supervision and
control over the implementation of cooperative agreements
between facilities."
3. Page 7, line 14.
Following: "20"
Insert: "and 37 through 44"
4. Page 7.
Following: line 18
Insert: "(3) 'Certificate of public advantage' or 'certificate'
means a written certificate issued by the authority as
evidence of the authority's intention that the
implementation of a cooperative agreement, when actively
supervised by the authority, receive state action immunity
from prosecution as a violation of state or federal
antitrust laws.
(4) 'Cooperative agreement' or 'agreement' means a written
agreement between two or more health care facilities for the
sharing, allocation, or referral of patients; personnel;
instructional programs; emergency medical services; support
services and facilities; medical, diagnostic, or laboratory

facilities or procedures; or other services customarily
offered by health care facilities."

Renumber: subsequent subsections

5. Page 10.
Following: line 15
Insert: "(8) The attorney general is an ex officio, nonvoting
member of the authority only for the purpose of the
authority's approval or denial of certificates of public
advantage, supervision of cooperative agreements, and
revocation of certificates of public advantage pursuant to
[sections 37 through 44]."

Renumber: subsequent subsection

6. Page 22, line 17.
Strike: "shall"
Insert: "may"
Following: "legislation"
Insert: "in addition to [sections 37 through 44]"

7. Page 73.
Following: line 8
Insert: "NEW SECTION. Section 37. Finding and purpose. The
legislature finds that the goals of controlling health care
costs and improving the quality of and access to health care
will be significantly enhanced in some cases by cooperative
agreements among health care facilities. The purpose of
[sections 37 through 44] is to provide the state, through
the authority, with direct supervision and control over the
implementation of cooperative agreements among health care
facilities for which certificates of public advantage are
granted. It is the intent of the legislature that
supervision and control over the implementation of these
agreements substitute state regulation of facilities for
competition between facilities and that this regulation have
the effect of granting the parties to the agreements state
action immunity for actions that might otherwise be
considered to be in violation of state or federal, or both,
antitrust laws.

NEW SECTION. Section 38. Cooperative agreements allowed.
A health care facility may enter into a cooperative agreement
with one or more health care facilities.

NEW SECTION. Section 39. Certificate of public advantage -
standards for certification -- time for action by authority.
(1) Parties to a cooperative agreement may apply to the
authority for a certificate of public advantage. The application
for a certificate must include a copy of the proposed or executed
agreement, a description of the scope of the cooperation

contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The authority may not issue a certificate unless the authority finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the authority denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the authority not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The authority shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application. When considered necessary or appropriate by the authority, it may hold a public hearing on the application.

NEW SECTION. Section 40. Reconsideration by authority.

(1) If the authority denies an application and refuses to issue a certificate, a party to the agreement may request that the authority reconsider its decision. The authority shall reconsider its decision if the party applying for reconsideration submits the request to the authority in writing within 30 calendar days of the authority's decision to deny the initial application.

(2) The authority shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The authority shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the authority must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

NEW SECTION. Section 41. Revocation of certificate by authority. (1) The authority may revoke a certificate previously granted by it if the authority determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the authority without giving notice and an opportunity for a hearing before the authority as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the authority within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the authority shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the authority, the agreement for which the certificate was issued is terminated.

NEW SECTION. Section 42. Appeal. A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the authority to deny an application for a certificate or a decision by the authority to revoke a certificate. A revocation of a certificate pursuant to [section 41] does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

NEW SECTION. Section 43. Record of agreements to be kept. The authority shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to [section 37 through 44]. A party to a cooperative agreement who terminates the agreement shall notify the authority in writing of the termination within 30 days after the termination.

NEW SECTION. Section 44. Rulemaking. The authority shall adopt rules to implement [sections 37 through 43]. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by [sections 37 through 43], and appeals; and

(3) to effect the active supervision by the authority of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect."

Renumber: subsequent sections

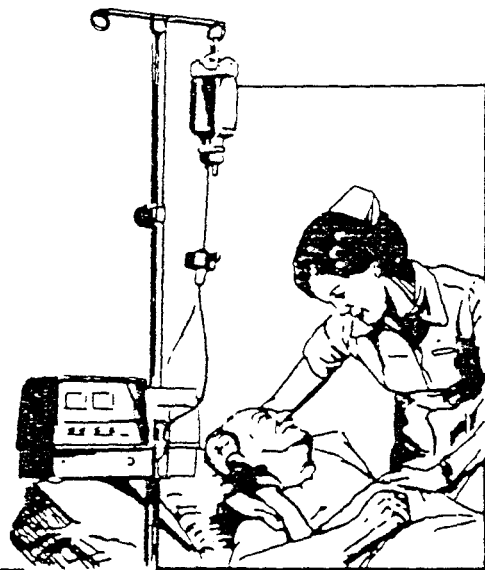
8. Page 73, lines 10 and 12.
Following: "20"
Insert: "and 37 through 44"

9. Page 73, line 17.
Strike: "37,"
Insert: "44, and 45,"

Report of the Health Care Cost Containment Advisory Council

This document is 39 pages long. The original is stored at the Historical Society, 225 North Roberts Street, Helena, MT 50620-1201. The phone number is 444-2694.

State of Montana
January 1987





Montana Nurses' Association

P.O. Box 5718 • Helena, Montana 59604 • 442-6710

EXHIBIT 1
DATE 3-24-93
SD 285

TESTIMONY ON SB285 Before the House Human Services and Aging

Committee: "An act Providing for Universal Health Care

Access, Health Care Planning, and Cost Containment".

BY: Wally Henkelman, RN, member of the Montana Nurses Association
and a Clinical Nurse Specialist practicing in Great
Falls.

The Montana Nurses Association (MNA) is the professional organization and authoritative voice of Registered Nurses in Montana representing approximately 1400 members across the state in a variety of health care and educational settings. All of the programs of MNA have as a primary goal the provision of quality health care for the citizens of Montana.

SB285, which has been presented after an enormous amount of collaborative effort by a committee with a diversity of professional backgrounds has three major purposes:

Increasing access to health care for Montanans

Maintaining or increasing the quality of health care

Maintaining or decreasing health care costs

Both the body of the bill (sections 1-21) and the "Small Employer Health Insurance Availability Act", (sections 22-36) specifically address all of these areas in a very positive manner. These

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purposes are certainly consistent with the goals of our association and deserve our support.

There are those who will propose to the committee or on the House floor that the bill be amended. In your consideration of those suggested amendments I urge the committee to ask three questions:

1. Does the amendment increase access to health care services ?
2. Does the amendment address the quality of health care services ?
3. Does the amendment help control the costs of care ?

I suspect that the explicit or implicit focus of most amendment proposals will not be related to those issues, but to possible limitations on reimbursement for health care services or products. We must all be aware, however, that significant health care reform must include cost containment which we know from experience has not been successful without limitations on reimbursement.

MNA strongly supports SB285 and urges you to forward this historic piece of legislation to the floor with a "do pass" recommendation.



Bringing lifetimes of experience and
leadership to serve all generations.

MONTANA STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr. Gene Quenemoen
606 Frank Road
Belgrade, MT 59714
(406) 388-6982

VICE CHAIRMAN
Mr. Robert J. Souhrada
915 13th Street West
Columbia Falls, MT 59912
(406) 892-4642

SECRETARY
Mrs. Florence R. Coslet
312 Cook Street
Lewistown, MT 59457
(406) 538-2674

EXHIBIT 10
DATE 3-24-93
SB 285

AARP Testimony
Health Care Bill SB 285
House Hearing March 24, 19

Mr. Chairman & Members of The Committee:

For the record, my name is Bill Olson and I am a member of the State Legislative Committee of AARP(American Association of Retired Persons). AARP has approx.110,000 members in the State of Montana-one for every eight persons in the state. AARP members are 50 years of age or older.

On behalf of the AARP State Legislative Committee, I appear in support of SB 285. This piece of legislation is extremely important to the citizens of Montana as it is the initial step in much needed Health Care Reform.

On a National level, AARP has developed a plan known as Health Care America. Providing health care for all is the primary goal of the plan, as it should be for any health reform plan. AARP's Health Care America calls for a multiple payor system as opposed to a single payor plan. SB 285 provides for the authority to recommend plans for both types, as outlined in Section 5, lines 11-24 on page 12. This concept we support.

The bottom line is that Health Care Reform legislation as proposed in SB 285, is urgently needed and AARP urges your committee's favorable consideration.

Thank you.

William Olson



Bringing lifetimes of experience and
leadership to serve all generations.

MONTANA STATE LEGISLATIVE COMMITTEE

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EXHIBIT 10
DATE 3/24/93
L SB 285

Montana AARP State Legislative Committee
1992-1993 Position Paper

STATE HEALTH CARE REFORM

POSITION: The goal is to reform state health care and long term care incorporating AARP's Health Care America approach of providing health care for all. Until the state system achieves such reforms, the Montana State Legislative Committee will support incremental legislative steps to achieve this reform.

PROBLEM: Too many people in Montana have no health insurance or at best are under-insured. This applies to young, elderly, retired and employed people as well. ("Reforming the Health Care System: State Profiles" -- Pages 79-81.)

Due to "cost-shifting" in an effort to pay for the uninsured, health care insurance costs are becoming prohibitive.

Billing and related paper work detract from the services of professionals and the hospitals. Additional personnel are required for clerical and administrative work. Duplication of paper work is also an on-going problem.

SOLUTION: State health care reform requires:

1. Incentives to employers, particularly small business, to provide health care insurance for their employees.
2. Coverage for all Montanans to abolish the need for "cost-shifting."
3. Consolidated billing allowing professionals to treat patients and not be bogged down with undue paperwork.
4. Establish a continuum of services emphasizing in-home care through custodial long term care.

CONTACT: Bob Souhrada, State Legislative Committee Member
915 13th Street West, Columbia Falls, MT 59912
(406) 892-4642



Bringing lifetimes of experience and leadership to serve all generations.

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Columbia Falls, MT 59912
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SECRETARY
Mrs. Florence R. Coslet
312 Cook Street
Lewistown, MT 59457
(406) 538-2674

HEALTH CARE REFORM

AARP'S KEY MESSAGES

For more information contact
Barbara Herzog, Director
AARP Health Care America
601 E. Street, N.W.
Washington, D.C. 20049
Phone (202) 434 2277

- **Cost Containment:** Across-the-board limits on the amount of money we, as a nation, pay for all health care services (e.g., hospitals, doctors, nursing homes and other health care providers). Cost containment should apply to both Medicare and non-Medicare services.
- **Universal Access:** All Americans should be able to receive health care--both prevention and treatment, including prescription drugs--when needed, and have adequate financial protection against health care costs.
- **Long-term Care:** Individuals, of any age, should have access to long-term care--either home/community-based or nursing home services--when they are needed, without fear of impoverishment.
- **Fair Financing:** Financing of the health care system should be equitable, broadly based, and affordable to all individuals.
- **Comprehensive Reform Legislated in a Package:** Implementation of comprehensive reform, including long-term care, should be based on a comprehensive package that is enacted all at once, but could take effect over time.

Compare against tape

EXHIBIT 11
DATE 3-24-93
SB 285

Mister Chairman and members of the Committee my name is Christine Mangiantini and I am the registered lobbyist for the League of Women Voters.

Statewide and nationally the League supports legislation that

1. provides access to a minimum basic level of care for all residents
2. a system that controls health care costs
3. the ability or lack of ^{ability of} a patient to pay for services should not be a consideration to receiving necessary medical care
4. support health care policies that include equitable distribution of services, efficient delivery of care, advancement of medical research and technology.

Senate Bill 285 encompasses all of these positions and provides an opportunity for the medical community, the insurance industry, and Montana residents to come together and craft health care legislation that meets the needs of our taxpayers.

Let us not sacrifice this opportunity ~~by giving way to special~~
~~interests whose vision ^{is} is parochial and short-term.~~

Mister chairman and members of the Committee before you today is the vehicle to change the way we do business in the health

care industry--for everyone and for the long-term.

The League of Women Voters urges passage of Senate Bill 285.

Thank you.

Boards

5 H.C. Planning Regions

Rep. from each county to represent
rural

p. 15 - cost containment.

(R's) Rehberg - for

(portability) - allowing consumer to
switch coverage among
small insurers.

sect. 30 - Reinsurance Bk. Pool

Jim Rice

MMA PROPOSED AMENDMENTS TO SENATE BILL 285

Page 13, Line 18

Following: {Section 5}

Insert: "should consider"

Strike: "must contain"

Page 15, Line 1

Following: "plans"

Insert: "should consider"

Strike: "must contain"

Page 15, Line 16

Following: "authority"

Insert: "may consider:"

Strike: "shall include"

Page 16, Line 21

Following: "plan"

Insert: "should consider"

Strike: "must contain:"

Page 20, Line 2

Following: "plan"

Insert: "should consider"

Strike: "must contain"

Page 21, Line 11

Following: "authority"

Insert: "should consider"

Strike: "must include"



**BlueCrossBlueShield
of Montana**

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

EXHIBIT 13
DATE 3-24-93
SB 285

**TESTIMONY ON SB 285
Before House Human Services and Aging**

Presented by Tanya Ask
Blue Cross and Blue Shield of Montana
March 24, 1993

Blue Cross and Blue Shield of Montana has worked hard over the last two years with a number of other Montana groups, institutions, businesses and individuals towards real health care reform for the citizens of our state. Health care costs and utilization have expanded beyond our abilities to pay. Hospitals, doctors, counselors, patients and insurers all need to be a part of the solution.

We testified in favor of Senate Bill 285 in the Senate, and have told a number of you and your fellow representatives of our continuing support for this bill. While issues such as practice parameters, prioritization of services, allocation of health care resources and the like deserve extensive discussion and careful deliberation, I will address two facets of this bill--Cost Containment and Health Insurance Reform.

In discussions we had with many of you last December, we at Blue Cross and Blue Shield of Montana stated our support for the type of insurance reform contained in Senate Bill 285. (Attached is a copy of the White Paper developed jointly by the Montana Hospital Association, the Montana Medical Association and Blue Cross and Blue Shield of Montana which identifies these reforms.) While this reform measure imposes insurance reform on the small group marketplace immediately, and studies reform for the entire marketplace to be reviewed by the Legislature in 1995, this approach is important. The vast majority of Montana employers are small businesses. We can correct some of the problems in the insurance marketplace now, begin reform now by imposing portability of coverage; allowing insurers to cancel or nonrenew coverage, NOT because of the health risk or claims experience of a groups or an individual within a group, but only for reasons like nonpayment of premiums; imposing rate bands on rates charged for coverage, shrinking the difference in premiums between one group and another; and guaranteeing access to health insurance coverage regardless of an individuals health status.

We have also stated that this reform is not without a cost. As you narrow the difference in rates between healthier groups and those with more health problems, many people are going to see an

increase in the cost of health insurance. That's what happens when you truly spread risk, not just insure those in good health. You need to be aware of this cost.

The small group reform proposed here will have even greater price ramifications to employers without meaningful health care cost control. Insurance prices are a symptom of the overall problem - price increases for services coupled with increased demands for services and utilization of those services by all of us. Without controlling those costs, the price we pay will only increase in direct proportion.

There is a major problem with Senate Bill 285 as it comes to you from the Senate. Subsection (j), lines 7-9 on page 48 needs to be removed. This section currently allows only one case characteristic - age - to be used in determining the premium rates for a group. That would mean the only characteristic that could be used in developing a rate for a group would be the age of the members in the groups without allowing consideration of any other demographic information about the group. This would result in an overnight return to community rating - a move that Montana small businesses could not absorb financially overnight. Subsection (j) also presents internal conflicts with other portions of the bill. We propose an amendment removing this provision and renumbering the subsequent provision to prevent this disaster. The sponsor of the bill has agreed she will not oppose this amendment.

We urge the passage of this very important bill with the amendment to remove section (j) on page 48.

EXHIBIT 13
DATE 3/24/93
1 SB 285

Blue Cross and Blue Shield of Montana

Amendment to Senate Bill 285

PROPOSED AMENDMENT

SB-285

Page 48, lines 7 through 9, Strike: "(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner."

Page 48, line 10, Strike : (k)

Insert : (j)

END OF AMENDMENT

WHITE PAPER

The following paper presents the proposed policy positions for HEALTHCARE MONTANA, a collaborative effort of Blue Cross and Blue Shield of Montana, the Montana Hospital Association and the Montana Medical Association. These positions were proposed and considered by a number of discussion groups at Healthcare Montana at Big Sky in June and again at Healthcare Montana II in Billings. Once approved by the Steering Committee and recommended to the respective sponsoring organizations' boards, the proposed policy positions will form the basis for the development of legislative proposals and organizational programs for health care reform in the state.

The paper addresses the seven common health care reform questions identified by Robert J. Blendon, Jennifer N. Edwards and Andrew L. Hyams in their article entitled "Making The Critical Choices," published in the May 13, 1992, edition of the Journal of the American Medical Association. The responses represent the sponsoring organizations' thoughts going into the September 19 and 20 meeting in Billings, and a synthesis of the thoughts of those attending that meeting. Some of the questions have been modified slightly to suit the circumstances in Montana.

1. Should everyone be guaranteed access, by law, to a health insurance plan?

Yes. The goal is that every Montanan should have access to a basic benefits package.

It is recommended that the State Legislature in 1993 create an independent board to make recommendations to the 1995 Legislature on several aspects of health care reform: these would include universal access, cost controls, and the definition of what is included in a basic benefit package. Such a package should emphasize preventive services and primary care. The design must also encourage improved consumer awareness in the use of health care resources. Recommendations also should be made concerning whether or not to cover long-term care, and if so, what level of service to cover and at what point in the reform transition process, and what level of mental health services should be included. The proposed position of HEALTHCARE MONTANA on coverage of these services is stated below under item 5.

The independent board must consist of physicians, hospitals, payers, consumers, and should be no more than five members.

2. How do we provide universal coverage?

The objective of universal coverage is to avoid cost shifting, which has led to the imbalance in health care financing.

Several options are being debated at the national level, including a single-payer option, a "play or pay" option, an employer mandate or "mandated play" option, and an individual responsibility option often referred to as the "consumer choice" option.

None of these options has won overwhelming support from the HEALTHCARE MONTANA Billings conference participants. The single-payer option, especially if the payer is the government, received very little support in this process. The "play or pay" option is viewed as being a back door to single payer governmental program and, consequently, has not generated support either. There is a level of support for the notion of individual responsibility, and some have recommended a tax-based system of funding with non-governmental or private sector payer to administer the programs; others have suggested a "mandated purchase" option where all individuals would be responsible for obtaining coverage either through their employers or on their own.

Based on the input from the discussion groups, the "mandated play" option remains the option with the most support. Several elements must be included with this option, however, such as:

- tax relief for small businesses that can demonstrate that this is an undue burden for them to meet;
- tax-based support for gap coverage for those not eligible for employer coverage;
- inclusion of the self-employed under the mandate;
- employer-employee cost sharing;
- means testing for the portion of payment falling to individuals;
- the identification of reasonable benefit package, given the burden that this could represent; and
- the request for an ERISA exemption to include all private plans in the state.

The determination of the best option, given the circumstances in the state, might be referred to the proposed advisory board.

The Steering Committee recommends the following additional steps in order to assure true and effective universal coverage:

- **Antitrust Reforms**

Allowances are needed in current antitrust laws to encourage cooperative efforts between and among health care providers. State legislative action could be a short-term goal.

- **Tax Reform and Other Efforts**

Special emphasis must be placed on providing incentives to small businesses to obtain insurance. Tax credits may not be effective because many small businesses may not end the year with a profit and, hence, a tax liability to which to apply such credits. Thus, tax deductions for premium expenses, tax subsidies, insurance pools and other mechanisms should be developed that address the Montana small business environment.

- **Insurance Reforms**

Reforms in insurance underwriting and marketing practices are essential to the success of health care reform. There is broad agreement that the following reforms should be enacted:

- a gradual move to community rating;
- elimination of preexisting conditions clauses;

- elimination of medical underwriting;
- a prohibition on cancellation or nonrenewal "for medical reasons"; and
- portability so that employees can carry coverage from one job to another.

For health benefit plans regulated at the state level, these would be short-term goals requiring legislative action; for plans covered under ERISA, these would be long-range requiring federal waivers which should be pursued as quickly as possible. To achieve total insurance reform, ERISA programs must be incorporated into these proposals.

- Public and Private Health Insurance Pools

Insurance risk pools or health plans would spread the cost of health care across the entire population. These pools in Montana could generate a large enough pool to achieve better overall rates for many small businesses, the self-employed, and individuals in the private market, while also expanding insurance coverage.

Medicaid and State Medical also should be incorporated into the statewide pool. These may be long-range goals because the public pool would require a federal waiver from Medicaid rules as well as Montana legislature approval.

- Community Networks

Networks, such as those envisioned in the reform proposals of AHA and the Blue Cross and Blue Shield Association, should be considered as a way to achieve universal access, control costs, and address specific health care needs of given communities. These networks, made up of hospitals, doctors, allied health care providers and insurers would provide coordinated health care for patients at the local level. Patients would use the network for all covered services.

- Federal Health Insurance Programs

Medicare, the VA, the Indian Health Service and CHAMPUS should be pooled with those individuals not insured in the workplace in a state-wide public or private pool. This is a long-range goal that would require action by Congress.

3. How do we address access to and availability of services in the rural environment?

We must assure access to, and availability of, primary health services in rural Montana. We also must realize that funding is limited for new technologies and specialized services in all locations of the state.

Several strategies have been identified for assuring rural access, including:

- increasing the supply of health care professionals in rural areas by
 - emphasizing primary care services,
 - encouraging the use of more mid-level practitioners and creating in-state training programs for mid-level practitioners,
 - providing financial incentives to aid recruitment and retention, including loan repayments for physicians and more efficacious use of specialists through incentives for specialists to visit these areas,
 - encouraging more satellite clinics,

- expansions of MAFs and other alternative hospital models, and
- support for federal efforts to provide incentives to encourage training of more primary care physicians and fewer specialists;
- greater use of telecommunications and computers to extend medical care and continuing education to rural areas;
- preference for investment in emergency transport systems over investment in rural health care facilities; and
- establishment of urban-rural hospital/physician networks and coalitions.

The three sponsors have traditionally supported the family practice residency program. A feasibility study is currently being conducted, and we need to await those study results before proceeding. Some concerns were raised at the September conference about the number of graduates eventually settling in Montana and the program's cost.

4. How will we pay for guaranteed access to health care?

We believe funding should be as broad-based as possible.

The following sources were supported for funding guaranteed access to health care:

- broad-based state tax reform that would generate additional general fund revenue for health care services;
- consumer cost-sharing through significant copayments, deductibles, partial employee payment of insurance premiums and penalties paid by those who do not obtain health insurance;
- money saved by instituting administrative reforms (single-billing), practice parameters, tort reform and other elements of cost containment identified below in item 6;
- an hourly-based employer tax used to pay a portion of the health insurance premium;
- an increase in the "sin tax" on alcohol and tobacco products; and

The Steering Committee recognizes the need for additional research to refine these methods of funding.

5. What health benefits should be covered by the plan, and how should patients' financial participation in service purchase be included?

We believe a basic level of benefits should include preventive services and encourage patient financial participation in the purchase of health care services.

- Basic Benefits

The recommendation to cover basic benefits was made above in item 1. To assist in defining basic benefits, the participants considered the Oregon approach to prioritizing services.

There was a strong sense of support for a logical approach to prioritizing services along the lines, if not in the same fashion as, the Oregon plan, especially given its strong emphasis on prevention and primary services. It was felt that such a process would be essential in the effort to gain control over health care expenditures, while being as nonpolitical as possible.

The positions of participants on other coverage issues were:

- **Defining "Necessary Care"**

The participants were very wary of an attempt to define what is "necessary." The desire was to rely more on the national outcomes research efforts than to set up a state system to define it. In the meantime, it was felt that using an Oregon system would help identify the most necessary care of all that is available without subjectively labeling specific procedures necessary or not.

- **Covering Long-Term Care**

There was strong sentiment against inclusion of LTC in the basic benefits program at this time. The reasons varied from the costs involved to the suggestion that it is not as much a health problem as a social problem. If and when it is covered, emphasis should be given to noninstitutional forms of care, such as home health care, respite care, etc.

- **Covering Mental Health**

Agreement existed that mental health benefits should be included in the basic benefits package, but with several restrictions. Mental health services should be included in the prioritization process; prevention services and "primary care" mental health services should be defined, if possible. Also, emphasis should be on outpatient services, greater use of peer counselling and support groups at the workplace and in the community and tighter credentialing of the various categories of counselors and the like.

6. **How should health care costs be controlled?**

We can no longer operate as though we are in a world of unlimited financial resources. Ending cost shifting, instituting financial incentives to eliminate marginal care, and establishing practice parameters, are long-term goals. During the 1993 Legislative session, several measures should be considered:

- **Statewide Planning Structure**

Participants discussed the Steering Committee's recommendation for state and regional planning bodies. While they saw both pros and cons with these planning bodies, they were supportive of the need for such a mechanism. They were together similarly in their caution that such bodies need to be more productive than the former HSAs and be as nonpolitical as possible, with them appointed and structured in such a way as to minimize partisan politics. Also, many supported the concept of local decision-making to the extent feasible within state limits, whatever they may be.

- **Tort Reform**

13
3/24/93
SB 385

5 745

The Steering Committee believes that tort reform is an integral part of cost containment, and includes, but is not limited to;

- a limitation on the amount of noneconomic damages;
- mandated periodic payment on future damages;
- reverse sliding scale limits on contingency fees;
- expert witness qualification;
- extension of the "Good Samaritan" rule to ERs; and
- making countersuits available for frivolous claims and reciprocal attorney fees.

- **Other Cost Saving Strategies**

The Steering Committee endorses other cost containment strategies, such as:

- establishing fee schedules for physicians and allied providers;
- establishing practice parameters;
- reducing the number of services offered, more effectively controlling resource utilization;
- making administrative reforms (e.g., single-billing, electronic claims submission);
- providing mixed incentives or mixed reimbursement packages for physicians;
- improving information management (e.g., reducing cost of hospital services through development of benchmarks); and
- networks/partnerships of physicians, hospitals and other providers and payers to provide coordinated care and reimbursement mechanisms, possibly using primary care physicians to initiate the coordination.

- **Fixed Spending Limits**

The notion of operating within a fixed amount of money for health care in the state was accepted (although the term "global budgeting" was not recommended), provided that local control was retained over individual health care decisions.

Expenditure targets were more acceptable to those not supportive of a fixed state budget, especially as an interim measure to get to a fixed budget. Mandatory rate setting to keep within a fixed state budget was recommended by one group; elimination of cost shifting and use of RBRVS were suggested by others. This area would be incorporated into the independent board's study process.

7. **Who should administer this health plan?**

A majority of the discussion groups opted in favor of an independent public/private entity, along the lines of the PSC. All agreed that it should be a body with a relatively small number of members, broadly representative of the state's citizens, appointed to longer terms to avoid political realignments with each new administration, and selected from nominations from both the provider and consumer sectors. Some suggested specific formulas and structures, and these suggestions should be considered by the Task Force as it develops a recommended structure.

EXHIBIT 13
DATE 3/24/93.
SB 285

Blue Cross and Blue Shield of Montana

Amendment to Senate Bill 285

PROPOSED AMENDMENT

SB-285

Page 48, lines 7 through 9, Strike: "(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner."

Page 48, line 10, Strike : (k)
Insert : (j)

END OF AMENDMENT

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TESTIMONY BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

MARCH 24, 1993

MISTER CHAIRMAN AND MEMBERS OF THE COMMITTEE, MY NAME IS SUSAN SWINEHART. I AM A LICENSED SOCIAL WORKER AND AM HERE ON BEHALF OF THE MONTANA MENTAL HEALTH PROVIDERS COALITION. THIS COALITION OF APPROXIMATELY 500 LICENSED SOCIAL WORKERS, PSYCHOLOGIST AND PROFESSIONAL COUNSELORS ^{is} ~~are~~ SUPPORTIVE OF SB 285 AND WE URGE THE COMMITTEE'S APPROVAL OF THIS LEGISLATION WHICH WILL BEGIN THE PROCESS OF INSURING THAT ALL MONTANANS HAVE ACCESS TO AFFORDABLE, QUALITY HEALTH SERVICES AND WILL MOVE TO IMMEDIATELY ADDRESS THE PROBLEM OF SMALL EMPLOYER ACCESS TO HEALTH INSURANCE FOR EMPLOYEES

ALTHOUGH WE SUPPORT SB 285 AND WE UNDERSTAND THAT THIS LEGISLATION IS INTENDED TO ADDRESS BOTH THE PHYSICAL HEALTH CARE NEEDS AND THE MENTAL HEALTH CARE NEEDS OF MONTANANS, WE ARE CONCERNED THAT SB 285 DOES NOT SPECIFICALLY STATE THAT MENTAL HEALTH CARE NEEDS ARE INCLUDED. IT HAS BEEN OUR EXPERIENCE THAT WHEN MENTAL HEALTH CARE NEEDS AND COVERAGE ARE NOT EXPLICITLY IDENTIFIED, BUT ARE SUPPOSED TO BE IMPLICIT IN THE TERM "HEALTH CARE" THEN MENTAL HEALTH CARE IS OVERLOOKED. ACCORDINGLY, IF THE COMMITTEE CONSIDERS OTHER AMENDMENTS TO THIS BILL, WE HAVE ONE NEW DEFINITION AND TWO TECHNICAL AMENDMENTS TO PROPOSE THAT ADDRESS THESE CONCERNS.

WE PROPOSE THAT SECTION 2, DEFINITIONS BE AMENDED BY THE ADDITION OF A NEW PARAGRAPH (10) AT LINE 22 ON PAGE 8 WHICH WOULD DEFINE

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THE TERM HEALTH CARE. NEW PARAGRAPH (10) WOULD READ "HEALTH CARE"
MEANS BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

IN ADDITION, WE PROPOSE THAT THIS DEFINITION ALSO BE USED IN THE
SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT, THIS COULD BE
DONE BY AMENDING SECTION 24 TO ADD A NEW PARAGRAPH (27) AT LINE 21 ON
PAGE 42. NEW PARAGRAPH (27) WOULD READ "HEALTH CARE" MEANS BOTH
PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

BEST COPY
AVAILABLE

LAST, WE ARE CONCERNED THAT NOT ONLY PHYSICAL HEALTH CARE
BUT ALSO MENTAL HEALTH CARE BE CONSIDERED BY THE COMMITTEE
RESPONSIBLE FOR RECOMMENDING THE FORM AND LEVEL OF COVERAGE TO BE
MADE BY SMALL EMPLOYER CARRIERS (SECTION 31 PAGE 67). THIS COMMITTEE
INCLUDES HEALTH CARE PROVIDERS. BUT AGAIN, WE ARE NOT SURE THAT
THIS INCLUDES MENTAL HEALTH CARE PROVIDERS. ACCORDINGLY, WE
PROPOSE THAT THE DEFINITION OF HEALTH CARE PROVIDER CONTAINED IN
SECTION 2 PARAGRAPH (6) BE MADE A PART OF SECTION 24. THIS COULD BE
DONE BY AMENDING SECTION 24 TO ADD A NEW PARAGRAPH (28) AT LINE 21 ON
PAGE 42, WHICH WOULD CONTAIN THIS DEFINITION. THIS MAKES IT CLEAR
THAT HEALTH CARE PROVIDERS INCLUDES ALL PROVIDERS OF HEALTH CARE
WHO ARE LICENSED, CERTIFIED OR OTHERWISE AUTHORIZED BY THE STATE.
SINCE MENTAL HEALTH PROVIDERS ARE SO LICENSED, THEY COULD BE PAR-
TICIPANTS IN DETERMINING COVERAGE TO BE MADE AVAILABLE. WE SEE THAT
THIS IS PARTICULARLY IMPORTANT IN THE LIGHT OF SECTION 33 (PAGE 69) OF
THIS PROPOSED LEGISLATION, WHICH APPEARS TO EXEMPT THE INSURANCE
MADE AVAILABLE TO EMPLOYEES OF SMALL EMPLOYERS UNDER THE BASIC
HEALTH BENEFIT PLAN FROM THE REQUIREMENTS OF THE EXISTING MANDATED
SERVICES.

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WE BELIEVE THAT THESE CHANGES WILL CLARIFY THAT MENTAL HEALTH CARE IS A PART OF THE SCOPE OF THIS LEGISLATION. WE WANT IT TO BE CLEAR THAT MONTANA RECOGNIZES THE RELATIONSHIP BETWEEN BEING HEALTHY PHYSICALLY AND HEALTHY EMOTIONALLY ~~AND WE WANT IT NOT ONLY TO THE HEALTH OF IT'S RESIDENTS KIDNEYS AND LIVERS BUT ALSO THE HEALTH OF THEIR EMOTIONS.~~

I APPRECIATE YOUR ATTENTION TO MY COMMENTS AND AM AVAILABLE FOR ANY QUESTIONS YOU HAVE. THANK YOU VERY MUCH.

BEST COPY
AVAILABLE

EXHIBIT 14
DATE 3/24/93
SB 285

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EXHIBIT 15
DATE 3/24/93
SB 285

Report to the Governor

Montana Task Force

BIOMEDICAL INFORMATION

Montana Task Force

This document is 27 pages long. The original is stored at the Historical Society, 225 North Roberts Street, Helena, MT 50620-1201. The phone number is 444-2694.

February 1993

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S.B. 285 - Create a Montana Health Care Authority -
Sen. Eve Franklin - Room 312² - 3:00 p.m. Wed.

Mr. Chairman, members of the Human Services and
Aging Committee -

I am Verner Gertelser, today I am
representing the Montana Legacy Legislature -

Among the five priority pieces of legislation
proposed by Montana Legacy Legislature their
first choice was legislation for Universal
Health Care. Montana senior citizens feel
that it is imperative that Montana develop
a system of care for all of its citizens -
Our present system is not working -
Thousands of Montanans are not receiving
adequate health care. Preventive health
care, which would pay for itself many
times over, is woefully lacking. Inadequate
pre-natal and early childhood care is
costing us not only in huge medical expenses
but in tragic human costs - Medical
costs are rising alarmingly, administrative
costs are eating too much of our health
budget, drug costs are skyrocketing?
Now is not a moment too soon to
begin to get a handle on our health care
system -

This legislation is the result of

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it is also the result of considerable
compromise - ~~We strongly~~ ^{Western}
Legislature strongly urge your
support of S. D. 285.

EXHIBIT 17
DATE 3-24-93
SB 285

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE
P.O. BOX 423 - HELENA, MONTANA 59624



(406) 443-5341

TESTIMONY OF DOUG CAMPBELL HEARD BEFORE (H) HUMAN SERVICES & AGING MARCH 24, 1993

Mr. Chairman and members of the committee my name is Doug Campbell. I live in Missoula, and I am president of Montana Senior Citizens Association. I am here to speak in support of SB 285. This legislation, which could provide universal and affordable health care for all Montanans, is the result of a bi-partisan citizens committee which, after several meetings and much deliberation, drafted this bill. Over the past couple of years, the citizens of Montana and the nation have been, not asking but demanding that something be done to address the health care problems of soaring medical costs, unaffordable health insurance and the 37 million of our citizens without any health insurance.

Now that President Clinton has granted the necessary waivers for Oregon to pursue their state health care reform plan and has indicated his willingness to let other states experiment with their own plans for health care reform, it is very important that SB 285 be passed in its present form. Let's put Montana in the forefront of the health care reform movement. SB 285 passed the Senate by a vote of 49 to 0, and if I was a

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member of this committee, I would not want to go home and try to explain to my constituents why I voted to kill this bill or weaken it with a series of amendments. On behalf of myself and our senior organization, I ask that you vote to pass SB 285 in its present form. Thank you.

EXHIBIT 18
DATE 3-24-93
SB 285

HEALTHMONTANA

SB 285

Mr. Chairman & members of the Committee

My name is Dale Pfau. I am Vice-President and General Manager of Don's, Inc. Don's, Inc. is a Central Montana small business consisting of three retail stores. I urge you to support SB 285 ~~in its present form~~ and to fend off any attempts to weaken the bill.

I strongly believe that the two most important factors in health care reform are universal access and cost containment. SB 285 is a start toward addressing the issues of, universal access for all Montanans, the burgeoning cost of health care in the state budget and will give small businesses involved with the purchasing of health care for their employees a reprieve from spiraling costs.

Along with my involvement in Don's, Inc., I have also been involved with Central Montana Medical Center in Lewistown for eleven years as a member of its governing board, three of which I served as president. During this time I have seen first hand the nightmares that so many uninsured Montanans experience when budgeting to pay for just their general health problems, notwithstanding what so many must live through when catastrophe strikes.

At present, Don's, Inc. pays for health coverage of all full-time employees. However, this coverage does not exempt us from having health insurance nightmares take place within our midst. Even though we have been fortunate enough to grow our family business from a GI tent in 1947 to almost 20,000 square feet of retail selling space, today we have fewer full-time employees than we had thirty years ago. The reason for this is not that we do not want full-time employees, full-timers tend to be a more efficient use of wage dollars, but that health care alone for these fewer full-time employees currently costs us in excess of \$25,000.00 per year. This represents 1.52 % of our gross sales. The percentage of health care to gross sales just five years ago was .77 %. The difference in these two figures represents a significant change for us when current costs of doing business in the State of Montana are added. Even though our business has out performed inflation virtually every year of its existence by a considerable margin, we continually fight to push the same percentage of dollars to the bottom line. Because of these escalating health care costs to our business, our many part-time employees fall through the cracks and do not receive from us nor can they afford adequate health insurance. Thus, many are subjected to the nightmares of affording to pay for their health care, or they just entirely ignore their health problems until it is too late.

For these reasons I urge you to take the first step toward controlling the costs of health care in Montana and providing universal access to its citizens by supporting SB 285.

All data that I can locate shows the average Small Gross Sales for businesses in Montana generating income between 190 and 390 net profit

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Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624



(406) 443-5341

SB 285

TESTIMONY BY CLYDE DAILEY ON BEHALF OF THE
MONTANAS FOR UNIVERSAL HEALTH CARE.

HOUSE HUMAN SERVICES AND AGING COMMITTEE

March 24, 1993

Chairman Boharski and Members of the Committee:

My name is Clyde Dailey and I am the Executive Director of the Montana Senior Citizens Association and the Chair of the The Montanans for Universal Health Care Coalition (MUHC), a coalition representing over 100,000 Montanans. I am speaking in support of Senate Bill 285. As you have already heard, the main features include the creation of a health authority, resource management plan, a database, and regional planning boards.

I am here today to address the regional planning boards and the health care planning regions as created by SB 285. We felt this is a key component of this legislation as it will provide for a comprehensive planning that will take into account the large population and geographic diversity that we have within Montana. We felt it was absolutely crucial to have local input for constructing a universal health care plan and specifically making recommendations about how resources should be

expended. With the cost containment goals set forth in this legislation, it was clear that local input was imperative in order to make intelligent decisions about how to manage the estimated two billion dollars currently in Montana's health care system. The vehicle for this decision making process will be the regional boards. The regional boards will be responsible for submitting an annual budget to the health authority. They will be responsible for revising the regional plan annually and holding public hearings within each region. A major component of these regional boards will be to seek input from the public as well as to educate the public as to how and why these resource allocation decisions are being made. The regional resource management plan for each of the five regions will be formulated and submitted to the five member health care authority for each of the five regions in order to establish a total health care budget in the state of Montana. The regions have been established based on a model provided by the Department of Health and Environmental Sciences that is in common use for many other planning activities for the state of Montana. An important feature is the ability of a county to petition to the health authority to be moved into another planning region. This process simply requires a written request by the board of county commissioners to be removed from a health care planning region and added to another

EXHIBIT 19
DATE 3/24/93
SB 285

region. The authority will grant the petition if it appears by the evidence presented that the county's health care interests are more strongly associated with another region.

It is clear is that we are in a state of crisis in our health care system in Montana and nationally. But the primary feature on which this legislation revolves is the resource management plan. We must know where the dollars are coming from and where the dollars are going in order to make the best decisions about how to contain costs and how to budget globally. I can only say in conclusion, representatives, be bold. The urgency of reform requires bold and innovative action. We have an historic opportunity. Let's make use of it. Montana has been a leader before. Let's be a leader again. Thank you for your time and consideration.

EXHIBIT 20

DATE 3-24-93

SB 285

MONTANANS FOR UNIVERSAL HEALTH CARE

"To assure affordable, accessible health care for all"

Christian Mackay, Coordinator

TESTIMONY OF CHRISTIAN MACKAY BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE ON SENATE BILL 285 - MARCH 24, 1993

Mr. Chairman, members of the committee, for the record my name is Christian Mackay. I am speaking today on behalf of Montanans for Universal Health Care, a coalition of teachers, senior citizens, labor, low-income groups, women, physicians, ranchers and farmers. We are here in strong support of SB 285.

Montanans for Universal Health Care came about because of a deep concern and a shared interest among its member groups on health care reform. The majority of groups have independently endorsed single-payer health care reform.

Early in this session, Montanans for Universal Health Care supported Senator Yellowtail's single payer bill, SB 267. We have not changed our position that a single-payer health care system is the best reform option. The political realities being what they are, it became evident that SB 285 would be the vehicle for reform in this session. We were able to compromise. Portions of Sen. Yellowtail's bill were amended into SB 285. Some examples are: specific health care policy for the state of Montana; several features that each statewide access plan must contain; specific components of the state health resource management plan, and individual county representation on the regional planning panels.

The compromise that was reached maintained the integrity of SB 285 and gave a forum for single-payer reform. Above all SB 285 is a health care reform plan designed by Montanans for Montanans. We cannot wait for the federal government to hand down an inappropriate one-size-fits-all scheme that doesn't work for this state.

It is a widely accepted fact that health care costs are the driving force behind the state budget crisis. This state must take the first step to reform this year. I urge all members of this committee to not only pass this bill, but to do your part to see that it is adequately funded. I urge your passage of SB 285.

EXHIBIT 21-313
DATE 3-24-93
SB 285

Robert J Ardis MD
One 16th Ave South
Great Falls, MT 59405-4108
March 25, 1993

House Human Services Committee
c/o Aylice Rice
Capitol Station
Helena MT 59620

To the Committee,

At the request of Aylice Rice, secretary of the Committee, I am writing down my comments at the hearing on March 24th, 1993 concerning SB 285, the Eve Franklin Bill.

I am a taxpayer and a voter. I represent only myself. I am a physician. I was a general practitioner in Wolf Point for 2 years. That lifestyle was too brutal so I went back to school. I am now an anesthesiologist in Great Falls. I work approximately 60 hours per week now. The hours are much less brutal (usually). As an anesthesiologist I am a relative bystander in the "health care access" problem. I have never refused my services to any patient.

Everyone agrees we have a problem. No one knows the answer. The problem is that we spend too much money on health care and yet not everyone has access to care. I have 3 general comments.

First, I hear no criticism of the general quality of medical care. The quality of the system is good. The access to the system is skewed.

Second, we all seem to agree that we need to provide medical care to those who presently have no access to the system. And we need to do it while cutting overall costs. Twenty percent cost savings with twenty percent more coverage. A big challenge.

Third, no one yet has looked at the long term health care effects of our aging population base. What will it be like when the baby boomers retire. I am a baby boomer. If you take the medical access problem of today and look at what the problems will be in 25 years (assuming no changes are made), you will think today's problems are easy. I hope SB 285 addresses the health care problems of the next 5 years. I hope SB 286 ages gracefully and is still valid in 25 years. Otherwise it is just another quick fix.

As I try to read and understand SB 285 I note several things. Some are good, some are bad.

First, the bill talks about single payor and multiple payor health care plans. I see the words "must contain" used frequently. I hope the phrase "must contain" means "must at least contain this...., but may additionally consider....". Specifically, I think other options than single and multiple payor plans should be able to be investigated. Perhaps a market-based system is more cost-effective. Perhaps it isn't, but you won't know if you don't check it out. Perhaps medisave accounts could be used to raise insurance premium deductibles. Perhaps practice guidelines could be established so there is less need to practice defensive

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medicine. I think some health insurance policies should be standardized - it is currently very difficult to comparison shop. I know that first hand because I recently decided my health insurance cost was too high and I tried to compare different companies policies. I think the patient should always be responsible for some co-payment of his medical bill. A patient's interest and involvement in his medical care increases as his out-of-pocket expenses increase. Indeed, that is the reason we are here today. So I think SB 285 must look at as many options as they can. We are idea shopping and idea comparing right now. There must be a mechanism to allow the as-yet-unthought-of-good-idea to rise to the surface and be tried.

Second, I think the idea of portability of insurance coverage is excellent!

Third, while reading SB 285 I see recurring phrases: "caps on expenditures", "global budgets", "cost containment", "negotiated budgets", "provider caps", "unified health care budget". To me it is all the same idea, best summed up in one word I have never seen used. RATIONING. Why don't we admit it and say we need to ration medical care. We already ration care by ability to pay. We all agree that is the problem. Our goal then is to ration medical care by another more equitable means. And yet stay within a decreasing budget. Never, never forget the cost. That is why we are here. I see several ways to ration medical care. I have no idea which is most equitable:

- 1) Financial resources - the current system
- 2) Waiting time - everyone is eligible for everything. And they deserve everything. Just take a number and stand in line.
- 3) Ranked severity of illness - the Oregon approach. 700 medical problems and their associated treatment costs are ranked from most important to least important. The available budget then determines how far down the list you can treat and pay.
- 4) Level of completeness - I'll use heart disease as an example. If you have chest pain from heart disease there are several things the medical community can do to treat it. The simplest is to tell you "if it hurts, don't do it". You then limit your physical activity, i.e. you don't shovel snow. The next level is to try various medicines, "take these nitroglycerin tablets under your tongue until the pain goes away". The next level is to discover the cause of the pain through various (increasingly expensive) tests up to coronary angiography. The final (and most expensive) treatment is to "cure" the disease with angioplasty or bypass surgery. (That is a somewhat oversimplified example). Do we all deserve "the best" when we are sick?

And so the debate begins. My concern is that the whole problem be debated and all possible options considered. So let us ration health care. Let's make it more cost-effective. Let's make it more uniform. Let's make it more equitable. Let's keep the quality high. And of course, let's keep the cost down. But be careful, all the work is done in the definition of those terms: cost effective, uniform, equitable, quality, cost.

Thank you and good luck,

Robert A. J. ...

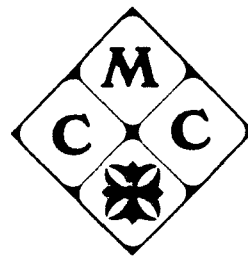


EXHIBIT 22
DATE 3-24-93

Montana Catholic Conference

SB 285

Testimony Senate Bill 285 - Create a Montana Health Care Authority

Chairman Boharski and Members of the Committee

My name is Sharon Hoff representing the Montana Catholic Conference. As Conference Director, I serve as the liaison for the two Roman Catholic Bishops of the State of Montana in matters of public policy.

The Montana Catholic Conference supports SB 285.

CRITERIA FOR HEALTH CARE REFORM:

Formulated by the United States Catholic Conference, the criteria affirm basic health care rights. The criteria include: (1) Universal access; (2) Priority concern for the poor; (3) Respect for life; (4) Comprehensive benefits; (5) Pluralism by encouraging the involvement of the public and private sectors; (6) Equitable financing based on ability to pay; (7) Cost containment and controls that reduce waste and inefficiency and provide incentives for effective and economical use of limited resources; and (8) Quality, which promotes the standards that will help achieve equity in the range and quality of services.

Health care reform is a primary issue facing our state and our nation. Without reform, costs will continue to rise and accessibility will become more limited. Too many Montana citizens have not health care. SB285 provides a direction to address our obligation to the common good, particularly to the needs of the poor and vulnerable.

Because SB285 meets most of the Conference criteria, we support this legislation and urge its passage.

OCAW

Oil, Chemical & Atomic Workers
International Union, AFL-CIO



EXHIBIT 285
DATE 3-24-93

Dan C. Edwards SB 285
International Representative
P.O. Box 21635
Billings, MT 59104

406 / 659-3253 (Home)

SB 285

Statement of:

Dan C. Edwards, International Representative
Oil, Chemical & Atomic Workers Int'l Union, AFL-CIO
P.O. Box 21635
Billings, MT 59104

669-3253

Statement for the House Human Services and Aging Committee, March
24, 1993, 3:00 p.m., Room 312-2. William Boharski, Chair

My name is Dan C. Edwards, International Representative for the Oil, Chemical and Atomic Workers International Union, AFL-CIO (OCAW). OCAW represents over 500 members in the State of Montana, including employees of the Conoco and Exxon refineries in Billings, the Cenex refinery in Laurel, the Montana Refining Company in Great Falls, and Montana Power Company in Cut Bank and Shelby.

This statement is to indicate support for HB 285.

OCAW is a member of the Montanans for Universal Health Care coalition (MUHC). Rather than to take the valuable time of this committee to repeat testimony of others, it will suffice to say that OCAW fully supports the testimony being offered today by MUHC.

Thank you for your consideration of our testimony.

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HOUSE HUMAN SERVICES AND AGING COMMITTEE
SENATE BILL 285 TESTIMONY
3/24/93

Mr. Chairman, members of the committee, for the record, my name is Michael Regnier. I work as the Advocacy Coordinator for Summit Independent Living Center in Missoula, and am also the state vice-president of the Coalition of Montanans Concerned with Disabilities. Today, I'd like to give you some information regarding the disability community in Montana and how we will be affected by Senate Bill 285. *over 500. We strongly support SB 285, but are opposed to the small group insurance reforms in house bill 5.*
According to statistics provided by the Rural Institute on Disabilities at the University of Montana:

* There are and estimated 44 million people with disabilities (i.e., that have one or more chronic or permanent impairment) in the United States; extrapolating from those figures, there are about 120,000 such individuals in Montana.

* Based on an estimate of 10 million people with severe disabilities nationally, about 27,000 Montanans would be expected to have severe disabilities.

* Nationally, two separate estimates suggest that the total cost of disability in the U.S. is about \$170 billion, or \$4000 per person with a disability annually; 51% of this cost is attributed to direct expenditures, while the other 49% is due to lost productivity.

* In Montana, the cost associated with disability could total \$480 million annually.

* 1980 Census figures support an estimate of 24% - 33% of the total rural population as having disabilities.

* The 1990 Census regarding mobility/self-care limitations and work disability status show that 4.9% of the adult population in Montana report having mobility/self-care limitations; 13% report having a work disability.

* While only 1.35% of those individuals with mobility limitations in Montana who are in the labor force report being unemployed, a whopping 89.82% are not in the labor market at all.

* According to a study done by the Rural Institute, with a sample population taken from consumer lists from three of Montana's Independent Living Centers and the state disability parking permit list, only 6% of Montanans with disabilities are employed full-time, while another 7% are employed part-time, leaving a total of 87% unemployed.

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EXHIBIT 24
DATE 3/24/93
SB 285

d workers in Montana were receiving
ity Insurance, while 7,568 were
Security Income, for a total of
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he fact that, of those people with
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from the labor market altogether.

disincentive costs Montana many
unnecessarily, and is largely due to
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Montanans, and while the bill will
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the small group insurance sections
or Montanans with disabilities and
it disabilities, with respect to
insurance. We simply cannot afford
for relief.

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ended to provide a comprehensive
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employment, effectively trapping
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of 3 to 25. These numbers were
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abilities, the bill still allows
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ands, it would be much better for
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ich call for true continuity of
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ll have the courage and good sense

Handwritten notes:
...the bill... I just took to...
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...though there are some problems for...
...the bill...

EXHIBIT 25 P01
 DATE 3-24-93
 SB 285

P.C.
 SURGERY
 STREET



MEMBER OF
 MONTANA
 ASSOCIATED
 PHYSICIANS, INC.

FAX: (406) 248-1036

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for the Health Care
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 ded to do the initial
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 that it is very important
 medicine be involved in

TON

P.2

EXHIBIT 26
 DATE 3-24-93
 SB 285

DALY MEMORIAL HOSPITAL CORPORATION

March 22, 1993

n
 Services and Aging

of the Committee:

Administrator of Marcus Daly Memorial
 am a member of Senator Baucus' committee

I have served on Governor Stephen's
 reform, and am a member of the American
 onal Policy Board.

tify in support of Senate Bill 285 and
 e members and the House do not amend any
 particular, access to care and cost
 change in health care must be dealt with
 sented to this committee, provides the
 is change. Special interest groups may
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trator the past 19 years, I have seen a
 very of care.

at Senate Bill 285 will address the needs
 h care providers and all Montanans, and

Sincerely,

JOHN M. BARTOS
 Administrator



THE WESTERN MONTANA CLINIC

515 WEST FRONT STREET
MISSOULA, MONTANA
59802

EXHIBIT 27
DATE 3-24-93
SB 285
TELEPHONE (406) 721-1000

March 23, 1993

Representative William Boharski
Chairman House
Human Services & Aging Committee
Capital Station
Helena, MT 59620

Dear Representative Boharski:

I would like to submit testimony for SB-285. I have had great concern and involvement in working on health care reform in Montana. A year ago I spent a two month sabbatical period in Senator Baucus's office in Washington as a health policy fellow, primarily working on health care reform. Since that time I have been a member of Senator Baucus's committee working on a health care reform plan which has evolved into the Eve Franklin Bill, SB-285. I strongly favor the Bill in its present form and particularly want to address the cost containment issue which is absolutely essential for any plan that offers universal coverage for Montanans.

Effective and predictable cost containment cannot be realized without adopting a global budget plan. Budgeting of this sort is working in many other countries. Global budgeting is practiced actually by prepaid plans and HMO's in this country. The negotiations can be satisfactorily arranged to control professional expenses, capital expenses and hospital budgets. They do need annual scrutiny and approval by a State Regulatory Agency in order to equitably use our limited resources. I think everyone would prefer to operate without a global budget, but with the annual inflation rate in health care continuing, drastic measures must be taken. You only have to look at your Medicaid budget to know what it is doing to the State's financial crisis. I would strongly urge you to approve SB-284 without amendment.

I would like to add that I have practiced internal medicine at the Western Montana Clinic for nearly 30 years. I am very concerned about the health care crisis and the need to get a State initiative in place. It is going to take a number of years for a Federal plan to address most of these issues and if we have a working plan in Montana we would be in a much better position to control our own destiny.

Sincerely yours,

William A. Reynolds
William A. Reynolds, M.D.

WAR:cs

SB 285 Third Reading
House Human Services & Aging

Chairman Boharski, Vice Chairman Simon, and Honorable Representatives of the House Committee on Human Services and Aging

I am Mike Schweitzer. I am a third generation native Montanan. My folks are still active raising cattle in Geyser, east of Great Falls. I have three brothers who own farms - one in Eastern Montana near Forsythe, one on the Highline near Ledger, and one in Western Montana near Whitefish. My oldest brother still has an interest in cattle with my folks. We are raising our children as the fourth generation in Montana. I would like to see my grandchildren grow up in Montana. I am very concerned with the future of Montana and its citizens.

Health Care is a very complex issue. I will only address a few aspects of the entire subject today. I would like to discuss the actual care that will and will not be available to each individual living in Montana. I will explore the limits to access to quality Health Care that Senate Bill 285 may impose on you, your families, and my family in its present form. I will outline some current estimates of the economics of the Health Care Industry and its impact on the State Budget. We will review the results of previous decisions by the state legislature regarding another government sponsored single payor system - Worker's Comp. I will mention a number of specific examples where these decisions drove businesses out of the state or prevented expansion of businesses in Montana costing the people of Montana hundreds of millions of dollars. A review of current approaches to health care, including the very high costs of government sponsored Health Care Plans, will be discussed. Finally, I will propose some amendments to Senate Bill 285 which will permit the authority more freedom to investigate and propose to the 1995 State Legislature two markedly different approaches to solving the complex issues of Health Care in Montana.

There are many excellent ideas in this bill. Initially, I was in favor of it. I came to Helena in February for the first reading of the Franklin Bill in the Committee on Public Health, Welfare & Safety chaired by Senator Dorothy Eck. I signed in as a supporter of the bill. Guaranteed access, portability of insurance coverage regardless of job status, prioritization of services, uniform insurance claims with electronic billing, a study of tort reform, plans for long term care, and a mechanism to gather the vast amount of economic data in order to calculate an actuarial sound estimate of the costs of implementing the plan through 2005 are all superb ideas in SB285. Now only six weeks later I find that I can not, in good conscience, continue to support the bill in its present form.

Montana Public Health Partners Inc., a Missoula Research group, indicates that more than 1.6 billion dollars was spent on health care in fiscal year 1990. If health care expenditure increases by 15% per year, then in 1991 the total projected cost will be 1.84 billion dollars, in '92 - 2.12, and this year, 1993 2.44 billion dollars. If you continue this projection to 1995 when the next legislature will be considering the proposals of the Health Care Authority authorized by this bill, then the estimate would be 3.2 billion dollars. **3.2 billion dollars** is a lot of money. According to a report in the Billings Gazette, Myles Watts (Chairman of the Agricultural Economics Department at Montana State University) the cash receipts for agriculture the past several years has been approximately 2 billion dollars each year. For 1993 the state's farm and ranch income should increase by only 1 %. This means that this year, 1993, the Health Care Industry is Montana's largest industry. This past weekend the Billings Gazette confirmed that Hospitals employed the most Montanans as compared to other industries. This number did not even include all those people employed by other segments of the Health Care Industry such as Physicians, Nursing facilities, pharmacies, and other health related industries. Another report in the Gazette listed the

fastest growing industries in Montana as Health Care and Tourism.

Montana Public Health Partners Inc. listed out-of-pocket expenses by Montanans as 383.4 million or only 23.4% of the total 1.6 billion dollars in 1990. This included co-payments, deductibles, and payments made by individuals directly to health care providers. Employer-based contributions, 26.7 % (438.5 million), included business insurance premiums, worker's compensation, and direct payments to health-care providers by self insured businesses. Public sources, including primarily federal and some state money, was nearly 50 % of the 1.6 billion dollars.

According to a report from HCFA Region VIII in Denver, the Federal share of the over 193 million dollars in Medicaid benefits for fiscal year 1991 was over 170 million dollars or 88%. For every 12 dollars spent by Medicaid for benefits, this state receives 88 dollars of Federal money. That is an incredible seven fold return on our investment by the state.

This fiscal year 1993 of the estimated 2.44 billion health care dollars, approximately 1 billion dollars of out-of-state money will flow into the state for health care based on projections from the Montana Public Health Partners. This out-of-state money not only helps pay for the medical care of our state's citizens, but also is apparently recycled about seven times in the state economy according to reports in the Billings Gazette. The initial payment to physicians, hospitals, visiting nurse companies, nursing homes pharmacies, and many other health related businesses is usually taxed by the state. This initial payment from out-of-state sources then pays the salaries of many Montanans including nurses, nurses aides, administrators, secretaries, medical technicians, janitors, etc. They use this income to feed, shelter, clothe, educate, and care for themselves and their families. In this process the money that was initially from out-of-state sources is recycled and taxed many times in the state of Montana. There are many ways reform could reduce this out-of-state income. I think it is very important to evaluate not only the expenses of medical care in Montana but also where the money currently comes from that pays these expenses. A reform that results in a bankrupt medical care system similar to what happened with Worker's Comp, would negatively impact the state budget and the incomes of many Montanans. The economics of medical care reform can not be overlooked and the impact on the economics of both the state and the citizens of Montana should not be underestimated.

Many businessmen have outlined for me many specific cases where businesses, their jobs, and taxable revenue have left the state or avoided Montana because of decisions by the state legislature regarding taxes or Worker's Comp. This cost the people of Montana hundreds of millions of dollars. (See Addendum A) I am concerned that if an additional heavy burden is placed on businesses for health care that the state of Montana and the citizens of Montana will continue to lose business and their resultant capital. This results not only in a loss of state revenue but also in a drain of a very important resource - our children. Many young, bright, energetic, citizens of Montana must leave each year to seek employment.

The current wording potentially **relegates Montanans to substandard medical care**. In an attempt to create a floor of basic medically necessary and effective health care benefits that no Montanan would fall below, the bill has effectively created a ceiling of uniform health care benefits that no one can rise above. If you or your family desires medical care that is not defined in the basic or standard health benefit plans, you will not be able to obtain that care (see pg. 15 section 3 b). A suggested amendment to correct this would be to add on page 19 at the end of section 8 after line 25 a subsection "(i) Nothing in this bill shall constrain Montana residents from seeking health care services not specifically delineated in the health care benefits package."

Even if the desired benefit is included but you wish to receive this care out of state, you may not be able to receive this care. The current Franklin Bill mandates that all payors of health care services pay the same rate public or private (pg.16 section 3 c). If your son or daughter has a medical problem that is currently best treated at a University or special clinic outside of the state, they may refuse to treat your son or daughter. You may well ask, "Why ?" The current Health Plan Mandates a specific payment for a specific service. What if that payment is deemed inadequate by the out-of-state provider? They would be within their rights to refuse to care for your ill child. Already many news publications are documenting the refusal of hospitals and physicians nationwide to care for patients with medical insurance plans with inadequate reimbursement. These are usually Medicare or Medicaid insurance plans - both of course are government sponsored plans with specific and well defined payment for a specific health care service. This is exactly the type of reimbursement plan that the Health Authority must propose to the 1995 legislature.

Leaving the state to seek health care is very common. Former Governor Stevens may not have been able to seek medical care in Washington state under the new Franklin guidelines. You probably have family members or friends who have gone outside the state for medical care. My nephew was in a coma in Whitefish Hospital with extremely high fevers. He was transferred to Denver Children's Hospital. After initially waking up blind, unable to talk or walk, he has recovered completely. My own son was diagnosed with a rare disease, Kawasaki Syndrome when he was two. He had a "Classic Case". These patients at that time often required open heart surgery for bypasses as children. He was diagnosed and treated in one of the few world wide centers that was involved in a research study involving Gamma Globulin. (Gamma Globulin is now the accepted treatment.) Instead of a 10-14 day hospital stay including open heart surgery, he went home in three days at considerably less expense. He recovered 100% without surgery. I doubt that either one of these boys would have been able to receive the same care or have the same excellent results in this new proposed global budget system. Even if we would have been willing and able to pay for the health care out-of-pocket, we may have been prevented by state law mandated by the Health Authority in order to comply with a uniform benefits system capped for provider expenditures and the other cost containment features.

The present plan handcuffs the Health Authority and they must follow the mandates included in the Bill. No flexibility is allowed in the present language. Changing one word on page 13 Section 6 (2) on line 21 from "**include**" to "**consider**" would give the Authority the freedom to choose truly different health care proposals. This one word change could provide a more fair and flexible study and evaluation of the two different health care plans. When the payments for services are well defined and mandated for all public and private payors, this prevents the individual from additional payments. It also takes away any competition. With the current language the multipayor system would collapse into a single payor system because of the cost containment mandates. In fact on pg. 24 it states, "On or before December 15, 1996, the Authority shall report to the legislature its recommendations concerning the feasibility and merits of authorizing the authority to act as an insurer in pooling risks and providing benefits, including a common benefits plan.." Amending this word would allow consideration of truly free market competitive multipayor systems. The Clinton administration seems to be in favor of competitive managed care multipayor systems which would not even be permitted in the current language of this bill.

Chairman Boharski has sponsored the Medisave Bill HB 670. This bill will help return the responsibility of health care to each one of us. The Medisave plan has a built-in incentive to wisely spend the first \$3000 annually. Each individual will become an interested consumer of health care. Currently, most money spent on health care in America is "government" or "insurance" money.

People consider these payments to hospitals, physicians, nursing homes, and for other such items as drugs, as 'other people's money'. This is our money disguised as a benefit from a company (resulting in lower true wages) or the government (resulting in higher taxes). The Medisave idea was supported by National Columnist Cal Thomas in the attached Billings Gazette article. He also addressed many of the problems with the Canadian system.

The New York Times has outlined the decline of the Canadian Health Care System. Medical costs in Canada are rising rapidly. Canada regulates hospital budgets and doctors fees in much the same fashion as currently proposed in SB285. Yet it actually costs more per person in *Canada than the U.S.A. for health care. The number you most often see quoted for Canadian Health costs is measured using the GNP as the denominator. The Canadian GNP has been rising much faster than the American GNP which has leveled off. As a consequence the comparison is not a true reflection of per capita health care costs. The provinces have been forced into ever larger deficits to pay health bills. The waiting lists for certain surgical procedures in Canada are so long that some patients die before their surgery. Other Canadians come to the U.S.A. for what they believe is **better more accessible medical care**. Do we really want to adopt a system that is failing not only in Canada but also in other socialized experiments?

terms of annual growth (26.3%) in

The March 11th Wall Street Journal has an article which indicates that the most expensive medical care per person in America is provided through Medicare and Medicaid, both government managed health care plans with very low out-of-pocket expenditures. Medicare averaged \$5,446 per person. Medicaid averaged \$3,565 for medical coverage only. The least expensive medical insurance care per person was provided to those citizens with high deductible insurance plans. Their average cost was \$1,333. These individuals were better consumers and spent their money more wisely. The Wall Street Journal concluded that, "The more a person's health care costs are subsidized ("insured"), the more likely they are to drive health spending upward."

In fact we will not be able to participate in any of the national or other state experiments. According to the Fiscal Note attached to this bill we tax payers will probably pay nearly 2 million dollars over the next two years just to study and propose regulations for a health plan that is already so well defined that it does not allow the people of Montana any significant input in the structure of the state plans. As thousands of brilliant minds all over our great nation explore and develop new plans for solving the health care problems, we will be locked into a system with a global budget, a ceiling of basic uniform health care, and an essentially single payor system run by the government. Do we really have so much money in this state that we can spend nearly two million dollars on a heavily biased and limited study to propose supposedly two separate health care plans that are essentially one. I don't think so...

Why not allow and even encourage the Authority and Regional boards the opportunity to explore real alternatives to propose to the 1995 legislature? We can propose the global budget, single payor, heavily regulated uniform benefits plan. Then we can allow some freedom for the authority to observe other states' plans and other proposals from think tanks around the nation as they are developed over the next 6-12 months. These two amendments would permit such freedom in the Authority's approach to these health care issues. If Montana is going to spend 2 million dollars to change its biggest economic industry why not provide two very different plans? What do you have to lose by allowing the flexibility to create two markedly different health care plans? Montanans can still vote to determine which, if either, plan to adopt.

Thank you for your time and consideration of these two amendments.

Addendum A

EXHIBIT 28
DATE 3/24/93
SP 285

I will mention just a few of the many examples of businesses and capital leaving the state and some of their reasons:

Industrial Plate & Grinding Moved to Sheridan 8 years ago. The company figures that the cost savings from lower Worker's Comp paid for their new building in 5 years

John Bradford - Bradford Roofing says the high cost of Worker's Comp makes it virtually impossible to compete against a Wyoming company. Whereas the Wyoming company pays 7 cents per dollar of revenue, his company pays 65 cents back to Montana for Worker's Comp for each dollar of Revenue

Joel Long - Long Construction builder of two major building projects in downtown Billings and many other smaller projects is no longer involved in major construction projects in Billings. Two of the reasons are Worker's Comp and the tax structure

John Foote a long time Billings resident and real estate investor moved to Arizona

Holly Sugar in Sidney and Western Sugar in Billings have many plants in other states that are more profitable because of the high cost of Worker's Comp and other taxes. Neither is building additional plants in Montana.

Sun Mountain Sports an international company with 350 jobs in Missoula, opened a new plant in South Dakota rather than Montana. They have spoken of leaving Missoula because of Worker's Comp and taxes.

Supersecrets for your health

■ **Question:** What are Hillary Clinton and her friends up to?

THE DIRECTOR OF the Congressional Budget Office, Robert Reischauer, may have pierced the darkness enveloping Hillary Rodham Clinton's secret meetings on health care reform.

Testifying before a House subcommittee, Reischauer said that any effort to bring health care costs under control will mean reduced medical services for all Americans.

Reischauer said managed care, an overhaul in malpractice litigation and cutting red tape will result in only modest savings. He said that covering the estimated 35 million uninsured will cost \$33 billion in 1994 alone. "Someone will have to pay these additional costs," he said. We know who that will be.

"If the savings from health care reform are used first to cover the uninsured," said Reischauer, "and then to reduce the high costs of private payers, not much will be left to reduce the costs of the federal programs."

Reischauer warned that "ending the tax subsidy for health insurance could also raise the number of uninsured," which means we would be back to where we started, but with the quality of health care reduced for everyone.

With so much at stake, it is outrageous that Hillary Rodham Clinton continued to bar the door to the public while she plotted in secret with her radical activist "friends." There are said to be up to 400 people "helping" her, but their names and qualifications are secret.

There can be only one reason for the secrecy. The plan is socialized medicine, and as much effort is going into strategies to mask that fact and to sell it as something else as into reforming the health care system itself.

If government manages health care, it will no longer be the best.

COMMENTARY



Cal Thomas
National columnist

Consider the Canadian health system, which many point to as a model America should follow. Socialized medicine in Canada has brought waiting lists for some surgical procedures. Many Canadian patients come to the United States for what they believe is better and more accessible health care.

Twenty-seven years after universal health insurance was adopted, Canada is now feeling the pinch. Canada uses tax money to pay most medical bills. It also regulates hospital budgets and doctors' fees. Yet, medical costs are rising rapidly, and for the first time patients are being required to pay extra for common medical services.

A New York Times story catalogues the decline in Canada's health care dream. Despite efforts to control costs, revenues in the public sector are not increasing fast enough. While the government once paid half the cost of the health system, it now pays only 30 percent. The provinces have been forced into ever larger deficits to finance health care, which now consumes about one-third of total spending. This contributes to Canada's foreign debt because provincial bonds must be sold abroad to underwrite the deficit.

Would you like to be told by the government which doctor you may see, or do you prefer to make your own choice? Would a surgeon who receives controlled fees have the incentive to increase his knowledge and improve his skills?

"I'm from the government and I'm here to help you" never looked like such an empty promise.

So how do we control medical costs with-

out sacrificing quality care? The answer may lie in eliminating or drastically limiting dependence on third-party health insurance, which is insurance provided by the government, an employer or an insurance company. Most payments to hospitals and doctors involve other people's money. Workers think this is a "benefit" from their employer, but it results in lower wages to the employee.

Instead of third-party insurance, how about trying medical IRAs? Employers now pay, on average, \$3,605 annually per worker for employee health plans, not counting employee contributions, according to the Employee Benefits Research Institute in Washington. If the employer put \$3,000 annually into an employee medical IRA, which the employee would use to pay the first \$3,000 of his medical costs, and bought a health insurance policy with the rest, perhaps adding some money to the pot as a small "benefit," so that all medical expenses above \$3,000 would be covered, perhaps the problem could be solved.

The employee would get to keep in the IRA any unspent portion of the \$3,000 in a calendar year. As long as it is spent on medical care, including dental care and eye wear, the money remains tax-free. If the employee spends it for anything else, it would be taxed as ordinary income.

Because most people spend less than \$3,000 annually on health care and because the medical IRA carries a built-in incentive to spend only when necessary, such a plan could control costs. A medical IRA would also follow an employee to a new job or stay with him if he lost his job, which the current system does not allow.

We don't know if anything like this is being discussed because of the closed-door policy at the White House. Let's open those doors and let the sun shine in.

Along those lines, a federal judge on Wednesday limited the authority of the task force to hold closed meetings.

It is our health and our money, and we have a right to know what Hillary and her "friends" are doing.

EXHIBIT 28

DATE 3/24/93

SB 285

SB 285 Third Reading
House Human Services & Aging

2/24/93

Chairman Boharski, Vice Chair Simon, and Honorable Representatives
of the House Committee on Human Services and Aging :

Suggested Amendments to SB 285

1. Pg. 19 Section 8 after line 25 a new subsection (i)
Adds: "Nothing in this bill shall constrain Montana residents from
seeking health care services not specifically delineated in the
health care benefits package."
2. Pg. 13 Section 6(2) line 21
Following : "must"
Insert : "consider"
Strike : "include" on the same line


Mike Schweitzer

I am testifying to support amendment then passage of SB 285-the Eve Franklin bill. The bill should be amended for two reasons: it limits the ideas that may be considered for health care reform by the Health Care Authority; and the requirements for any plan (listed in sections 6, 7, 8, 9, 11, and 20) are at best, of questionable value. The specific suggestions for amendment are listed in Table A; the rational for these suggestionns follow Table A.

TABLE A

Section	Page	Line	Current Wording	Proposed Substitution
6	13	18	must contain	should consider
7	15	1 and 16	must contain	should consider
8	16	21	must contain	should consider
9	19 20	2	must contain	should consider
11	21	11	must include	should consider
20	33	10	insurer shall:	insurer shall consider:

An alternate to these proposed changes would be to require that the Health Care Authority offer a "market oriented" plan in addition to single and multi payor plans.

The idea of considering options and presenting them by 10/1/94, as the bill requires, is reasonable. However, as currently worded the bill does not allow substantially different options to be considered. Instead it limits debate at the outset and excludes consideration of any ideas not consistent with the predetermined assumptions and outcome it mandates.

It accomplishes this primarily in sections 6, 7, 8, 9, and 11. The opening lines of each of these sections mandate the type of options which may be considered by stating that any plan considered "must contain" or "must include". I would urge you to amend these sections so that those features listed are "considered", but not required unless the Health Care Authority chooses that option. Section 20 should likewise be amended to allow consideration of mandating managed care by the Authority, but not necessarily requiring it. Many believe that managed care is at best a mediocre idea; the Authority should be able to accept or reject those ideas after consideration.

Arguments for and against many of the requirements in these sections can be made; including global budgets, controlled capital expenditures, capped provider expenditures, negotiated annual budgets, procedures for health care monitoring, et cetera. The

Authority should be allowed to hear those arguments and make recommendations; not have their position dictated by the bill.

These sections make a myriad of assumptions; not only regarding the general philosophy of Health Care reform (more bureaucratization is better), but also what specific treatments should be allowed. This is done without any discussion regarding the cause of the problems or of alternate solutions. For example, in reviewing 13 published plans for Health Care Reform 10 could not even be considered as options under SB 285 since they do not accept the premises or include the requirements specified in SB 285, see Table 1.

TABLE 1

Compatibility of the "must contain" mandates of SB 285 with 13 published Plans for Health Care Reform.	
NOT COMPATIBLE	COMPATIBLE
SB 285 would Prohibit	SB 285 would Allow
The Pepper Commission's Blueprint for Health Care Reform-U.S. Senate ¹	Restructuring Health Care in the U.S.-D. Nutter, M.D., Northwestern Univ. School of Medicine. ¹
Health Access America-AMA ¹	The 'US Health Act'-U.S. Representative E. Roybal, Washington D.C. ¹
Physicians Who Care Plan-Phys. Who Care ¹	Liberal Benefits, Conservative Spending-K. Grumbach, M.D., Phys. for a NatL. Health Program ¹
Plan to Achieve Universal Health Insurance-Karen Davis PhD-Dept. of Health Policy & Management, Johns Hopkins University, Baltimore, Md. ¹	
A Framework for Reform-the Kansas Employer Coalition on Health	
Universal Health Insurance-A.C. Enthoven PhD, Grad. School of Busi. Stanford, Calif. ¹	
An American Approach to Health System Reform-John Holahan, PhD, The Urban Institute, Washington, D.C. ¹	
Health Care Reform-Save Butler PhD, Heritage Foundation, Washington, D.C. ²	
Keeping the Promise-the American Legislative Exchange Council ³	
State Health Care Reform Under the Clinton Administration-John Goodman, PhD Nat. Center for Policy Analysis ⁴	

1-JAMA; May 15, 1991, Vol 265, No. 19

2-Critical Issues

3-Keeping the Promise

4-Natl. Center for Policy Analysis

The second reason to amend the bill in this fashion is that the mandates of sections 6, 7, 8, 9, 11, and 20 are of unproven benefit. Despite the popular arguments for these ideas there is considerable evidence that many of these ideas do not accomplish the desired goal. For example consider the ideas of "Global budgets" (as mandated in section 6) and universal access. These are two requirements of the Canadian system and other countries with similar systems. Here are some comments from Canadian observers.

- Twenty-four people died in 1989 while waiting for heart surgery in British Columbia.-*Ottawa Citizen, Feb. 4, 1989*
- Patients in British Columbia must wait for up to a year for simple, routine procedures such as cholecystectomies, hip replacements, prostatectomies, and surgery for hemorrhoids.-*Waiting your Turn: Hospital Waiting Lists in Canada*
- In January 1989, extensive waiting lists forced Toronto's well-respected Hospital for Sick Children to send home 40 children awaiting heart surgery.-*Maclean's, Feb. 13, 1989*
- Earlier this month, the Ontario Hospital Association announced that the 224 hospitals in the province are facing massive job cuts and bed closures because the provincial government cannot provide the \$630 million needed to maintain the current level services.-*Maclean's, Nov. 25, 1991.*

Are these observations just flukes? The statistics regarding waiting times in British Columbia are listed in Table 2 on the next page.

Finally consider the report in The Wall Street Journal yesterday 3/23/93. David Miller, an 83 year old Winnipeg entrepreneur, was told he would need to wait 6 months to have his hernia repaired. Now "Mr. Miller is teaming up with a U.S. insurer, American Medical Systems of Wisconsin, to offer an escape hatch. For \$450 a year, Canadians will be able to buy a policy that will ship them south for treatment whenever the waiting list is 45 days or longer. The policy even covers food and lodging for a loved one, plus airfare. The plan will be unveiled 3/24/93 in Canada, and reportedly the first 200 customers will be doctors." One could argue that the legal "guarantee" of access in Canada is really legal fiction.

Similar arguments can be made for most of the mandated requirements of SB 285. Only an attempt at brevity prevents me

from doing so. The point is not necessarily to persuade you that the Canadian or any other system is bad or good. The point is that SB 285 should not dictate what type of reform the Health Care Authority may consider. There are serious and substantial arguments & evidence against the recommendations SB 285 would mandate. The Health Care Authority should be free to consider and act on all options and arguments in making their recommendations. As currently worded the Authority may only offer plans with essentially one set of options.

Surely it is not in our best interest to limit the ability of the Health Care Authority to consider and recommend various options or to limit them to one set of preconceived ideas. With the mandates of the sections mentioned above there is little significant difference between a single or multi payor system since both would deliver care and control costs by the same mechanisms. We need a bill which has the courage to consider all the options and give Montanans' some real choices. Please amend SB 285.

TABLE 2
WAITING TIMES IN CANADA:
BRITISH COLUMBIA, 1989-1990

Procedure	Average Wait	Longest Wait
Bypass	5.5 months	7 months
Other Open-Heart Surgery	4.9 months	7 months
Hernia Repair	5.7 months	1 year
Cholecystectomy	7.3 months	1 year
Hemorrhoidectomy	6.4 months	1 year
Varicose Veins	8.3 months	1 year
Hysterectomy	3.7 months	7 months
Arthroplasty (hips, etc.)	3.9 months	1 year
Prostatectomy	7.1 months	1 year

Source: Steven Globerman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute) May 190. Quoted by NCPA Policy Report No. 128, December 1991, page 18.

Conclusions published in 1987 by the Canadian government in
Canadian Hospital Costs and Productivity:

- 1-"Canada's hospital expenditures grew at an average annual rate of 15 per cent" (1960 to 1980),
- 2-"the productivity of hospitals has not improved over the years; instead it declined",
- 3-"government policies aimed at curbing the excessive growth of health care costs have been of the cut, freeze, and squeeze variety and have not resulted in a basic redesign of the health care delivery system".

Source: 2. Auer, L: Canadian Hospital Costs and Productivity, A study prepared for the Economic Council of Canada. Canadian Government Publishing Centre, Supply and Services Canada, Ottawa, Canada K1A 0S9 1987.

Claude Castonguay, father of Quebec's health care system (the oldest in Canada) has called for privatization and competition in the supply of health services.⁶

SPENDING ON PHYSICIAN SERVICES BY HOSPITAL DISTRICTS¹ IN BRITISH COLUMBIA, 1987-88

Hospital Districts	Total Spending	Specialists	OB/GYN	Psychiatrists	Internists
Urban Districts:					
Vancouver	\$345.6	\$214.0	\$11.5	\$14.0	\$26.4
Victoria	348.4	211.8	8.5	13.2	25.6
Selected Rural Districts:					
Bulkley-Nechako	211.0	95.9	3.5	0.7	11.2
Cariboo	203.9	96.9	5.8	1.0	9.2
Central Coast	105.4	89.3	4.9	0.5	6.7
Columbia-Shuswap	188.0	88.3	3.5	3.4	9.5
East Kootenay	224.7	99.9	3.1	0.4	7.7
Kitimat-Stikine	193.2	103.9	5.8	0.3	10.0
Mount Waddington	167.2	75.6	6.5	0.9	5.2
Peace River	164.1	76.0	6.4	0.4	3.1
Skeena-Queen Charlotte	188.5	84.8	3.9	0.4	7.8
Squamish-Lillooet	205.7	89.5	6.3	2.0	8.8
Stikine	58.2	17.5	2.0	0.1	2.5
Fort Nelson/Laird	169.3	37.1	2.1	0.3	1.7
Average for all Rural Districts	253.8	138.1	7.2	4.0	7.0

Source: Pacemaker data by Eli Lilly Co. CAT scanner data by NCPA. Chronic renal failure data by Office of Health Economics, *Renal Failure: A Priority in Health?* (London: OHE) 1978, Table 7, p. 30. Data on Canada by Mary-Ann Rozbicki, *Rationing British Health Care: The Cost/Benefit Approach*, Executive Seminar in National and International Affairs, U.S. Dept. of State, April 1978, p. 22. U.S. figures estimated from data by the Department of Health, Education and Welfare. Quoted by NCPA Policy Report No. 128, December 1991, page 13

¹Based on fees paid to physicians rendering services to patients living in the district indicated, regardless of the area in which the service was performed. All figures are age/sex standardized by regional hospital district and expressed in Canadian dollars.

**SPENDING ON PHYSICIAN SERVICES PER PERSON IN BRITISH
COLUMBIA¹**
(1987-1988)

Specialty	Urban ²	Rural ³	Urban/ Rural
All Physician Svcs	\$347.1	253.8	137.0%
General Practice	132.1	115.7	114.0%
Specialists	214.6	138.1	155.0%
Anesthesia	16.6	6.9	241.0%
Dermatology	5.0	1.8	278.0%
General Surgery	11.9	12.4	96.0%
Internal Medicine	26.3	15.8	167.0%
Neurology	3.9	2.1	186.0%
Neurosurgery	2.2	1.2	183.0%
OB/GYN	11.0	7.2	153.0%
Ophthalmology	16.1	8.8	183.0%
Orthopedic Surgery	8.5	7.1	120.0%
Otolaryngology	5.1	3.8	134.0%
Pediatrics	5.6	3.8	147.0%
Pathology	44.0	35.0	126.0%
Plastic Surgery	3.2	1.3	246.0%
Psychiatry	13.9	4.0	348.0%
Radiology	30.9	21.6	143.0%
Thoracic Surgery	3.8	0.7	543.0%
Urology	5.7	4.0	143.0%

Source: Arminee Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia) 1989, pp. 121-176. Quoted by NCPA Policy Report No. 128, December 1991, page 50

¹Based on fees paid to physicians for rendering services to patients living in the areas indicated, regardless of the area in which the service was performed. All figures are age-sex standardized and expressed in Canadian dollars.

²Greater Vancouver and Victoria regional hospital districts.

³Twenty-seven non-metropolitan hospital districts.

INTERNATIONAL HEALTH CARE SPENDING
(Excluding Costs of Administration, Hospital Construction
and Research and Development)

Country	Spending as a Percent of GNP 1988	Annual Real Growth as a Percent of U.S. 1980-1988	Annual Real Growth Per Capita as a Percent of U.S. Rate 1980-1988
Austria	8.05%	114%	207%
Belgium	7.35	101	187
Canada	8.36	185	263
Denmark	8.35	47	86
France	8.50	225	381
Germany	8.44	158	296
Ireland	9.17	81	108
Italy	7.71	229	412
Japan	6.88	172	268
Luxembourg	6.69	155	270
Netherlands	8.31	38	25
Spain	7.11	70	84
Sweden	9.19	50	76
Switzerland	7.84	156	242
United Kingdom	6.35	102	180
United States	10.19	100	100

Source: Dale A. Rublee and Markus Schneider, "International Health Spending: Comparisons with OECD," *Health Affairs*, Fall 1991, Ex. 3 and 4, pp. 193, 195. Quoted by NCPA Policy Report No. 128, December 1991, page 8.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

House Human Services

COMMITTEE

BILL NO. SB 285

DATE 3-24-93 SPONSOR Sen. Franklin Ellis

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Chazia Paladichuk	Richland Co. Commission 2117. Hawthorn Court	✓	
Terri Roper	Mountain View Housing	✓	
Doug Campbell	MSCA	✓	
Alie Campbell	MCNHR	✓	
Clyde Daily	MT Senior City Assoc	✓	
Christian Mackay	MTNS. for Universal Health Care	✓	
Michael Regnier 1010 Fairview - Missoula	Coalition of Montanans Concerned w/ Disabilities	✓	
Paul Peterson 2115 Tanager - Missoula	ic	✓	
Bill Olson	AARP	✓	
BOB ARDIS	myself	partly	partly
Jammy VanderGarde MD	myself		✓
John Gregory	HMA	✓	
DALE PFAN	Don's Inc	✓	
Mike Schweitzer MT	Self		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB285
DATE 3/24/93 SPONSOR(S) Sen. Bob Hunter
PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Christine Mangranti Box 113, Helena	League of Women Voters	X	
Steve Browning	MT Hosp Assn	X	
Mike O'Keefe	State Auditor	X	
Bimb Dooker	MT Nurses Assoc.	✓	
JUDITH CARLSON	MT CHP, NAR ASSN SOCIAL WORKERS	✓	
Tanya ABK Box 274	Blue Cross + Blue Shield MT	✓	
Bob Christensen - LOLO MT	Montana People's Action	✓	
Kawtha Kelman	MCMACH	✓	
Tom Hopgood	Health Ins. Assoc. Amer.	✓	
Mary McCue	MT. Clinical Mental Health Counselors Ass'n	✓	
Mary McCue	MT. Dental Ass'n	✓	
Sim Meadenhall	Physician		X
HARLEY WAXLER	ASSOC. OF CHURCHES	✓	
Steve Turkiewicz	NADA Insurance Trust	With AMEND	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB285
DATE 3/24/93 SPONSOR(S) Sen. Bob Luetken
PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
<u>Spencer Eubank</u>	<u>MM HRC</u>	☒	☐
<u>Elizabeth Dore</u>	<u>NIASW Assoc. of Social Workers</u>	☒	☐
<u>Katharine Donnelly</u>	<u>N+M</u>	☐	☐
<u>David Owen</u>	<u>MT Chamber of Commerce</u>	☒	☐
<u>Phil Campbell</u>	<u>MSA</u>	☒	☐
<u>Doni Judge</u>	<u>MT STATE AFL-CIO</u>	☒	☐
<u>LARRY AKEL</u>	<u>MT ASSOC OF LIFE UNDERWRITERS</u>	☒	☐
<u>R. Chokman</u>	<u>State Farm Ins</u>	☒	☐
<u>Ted Lange</u>	<u>Northern Plains Resource Council Big Muddy Resource Council</u>	☒	☐
<u>Jim Radtke</u>	<u>MT STATE PEOPLE'S ASSOC</u>	☒	☐
<u>Suzy Holt</u>	<u>MT TASK FORCE FOR BIOMEDICAL INFORMATION</u>	☒	☐
<u>JAMIE DUGGETT</u>	<u>MT Cattlemen</u>	☐	☐
<u>Sen. Bill Yellowtail</u>	<u>Senator</u>	☒	☐
<u>Mona Lamson</u>	<u>P.T. Association</u>	☒	☐

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

James Lewis COMMITTEE BILL NO. SB 285
DATE 3/24/93 SPONSOR(S) Sen. Lou Lunn

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Paul Gassuch MD	Self		✓
Dale Schuler	Self		✓
Wally Hummelman RN	Mont. Nurses Ass'n	✓	
Alvin Ancelet	GOV	✓	
Allen Christensen 100 4th Ave N Great Falls	Montana Peoples Action	X	
CHET KINSEY	MSCA -MLIC	✓	
Tom ERDIE	Self	✓	
Teresa Henry RN	Kathleen Long RN Co. Chair HHA MT	✓	
Tommy Bertelson	Legary Legislature	✓	
John Wyman	Montana Peoples Action	✓	
Jan Dean	A Citizen's Private Perspective		X
Steve Riley	MFT MFSE MT Fed Health Employees	✓	
Dr Jeff Stricker	MT Academy of Chiropractors	✓	
Keith S. Cobb	AFLAC	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB 285
DATE 3/24/93 SPONSOR(S) Sen. Eve Iversen
PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
J. Shontz	Mental Health Assn of MT	☒	☐
Chuck Butler	Blue Cross and Blue Shield of Montana	☒	☐
Jim Fleischmann	MT People's Action	☒	☐
Jim Smith	Mt. Psych Assoc.	☒	☐

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By CHAIRMAN BILL BOHARSKI, on March 26, 1993, at
3:00 p.m.

ROLL CALL

Members Present:

Rep. Bill Boharski, Chairman (R)
Rep. Bruce Simon, Vice Chairman (R)
Rep. Stella Jean Hansen, Vice Chair (D)
Rep. Ellen Bergman (R)
Rep. John Bohlinger (R)
Rep. Tim Dowell (D)
Rep. Duane Grimes (R)
Rep. Brad Molnar (R)
Rep. Tom Nelson (R)
Rep. Sheila Rice (D)
Rep. Angela Russell (D)
Rep. Tim Sayles (R)
Rep. Liz Smith (R)
Rep. Carolyn Squires (D)
Rep. Bill Strizich (D)

Members Excused: Rep. Barnhart

Members Absent: None

Staff Present: David Niss, Legislative Council
Alyce Rice, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: None
Executive Action: SB 285

EXECUTIVE ACTION ON SB 285

Discussion: CHAIRMAN BOHARSKI presented a table of contents to
SB 285 for quick reference. EXHIBIT 1. REP. BOHARSKI said all
amendments to SB 285 haven't been drafted yet. The plan is to
work on the amendments that are available at this time, and
finish on Monday when the rest of the amendments will be
completed.

Motion: REP. RICE MOVED SB 285 BE CONCURRED IN.

Discussion: CHAIRMAN BOHARSKI said that about a week ago he had met with staff of the insurance commissioner's office, the staff attorney, and people from the industry to discuss technicalities in the second half of the bill. He presented amendments that resulted from that meeting.

Motion: CHAIRMAN BOHARSKI moved to adopt amendments 1 through 16, of amendment 6 to SB 285. EXHIBIT 2.

Discussion: David Niss, Legal Counsel, explained the amendments.

Vote: Voice vote was taken. Motion carried unanimously.

Discussion: CHAIRMAN BOHARSKI presented and explained amendment 5 to SB 285.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt amendments 1 through 9 of amendment 5 to SB 285. EXHIBIT 3. Voice vote was taken. Motion carried unanimously.

Discussion: REP. NELSON presented and explained amendment 8 to SB 285 which strikes the prohibition against small group carriers using case characteristics other than age without the approval of the Commissioner of Insurance.

Motion/Vote: REP. NELSON moved to adopt amendment 8 to SB 285. EXHIBIT 4. Voice vote was taken. Motion carried 12 to 3. REPS. RUSSELL, DOWELL, and SQUIRES voted no.

Discussion: CHAIRMAN BOHARSKI presented and explained amendment 7 to SB 285.

REP. RICE spoke against the amendments because she said there was an agreement to leave section 33 as is.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt amendments 7 to SB 285. EXHIBIT 5. Voice vote was taken. Motion carried 10 to 5.

Discussion: REP. SIMON presented and explained amendment 13 to SB 285.

Motion/Vote: REP. SIMON moved to adopt amendment 13 to SB 285. EXHIBIT 6. Voice vote was taken. Motion carried unanimously.

Discussion: CHAIRMAN BOHARSKI presented and explained amendment 9 to SB 285.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt amendment 9 to SB 285. EXHIBIT 7. Voice vote was taken. Motion carried 9 to 6.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt a conceptual

amendment to SB 285 that would change the language regarding who pays the administrative costs of the reinsurance committee, back to what was originally in that section of the bill. Voice vote was taken. Motion carried 15 to 0.

Motion/Vote: REP. SIMON moved to adopt amendment 10 to SB 285 which adds hospitals to the list of providers exempt from certificate of need, which the authority is to study to determine if that exemption should be continued. EXHIBIT 8. Voice vote was taken. Motion carried unanimously.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt amendment 11 to SB 285, which adds "Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person", to page 33, line 3. EXHIBIT 9. Voice vote was taken. Motion carried unanimously.

Motion/Vote: REP. SIMON moved to adopt amendment 12 to SB 285. EXHIBIT 10.

Discussion: REP. SIMON said the bill establishes a target for cost containment so that by 1999, the annual average percentage increase in statewide health care costs does not exceed the average annual percentage increase in the gross domestic product, as determined by the U. S. Department of Commerce, for the five preceding years. REP. SIMON said that is an unrealistic target, and he didn't see the relationship between gross domestic product and health care provisions. The amendment would strike "component", and add "including annual cost containment targets".

Motion/Vote: CHAIRMAN BOHARSKI made a substitute motion to adopt amendments 1, 3 and 4, of amendment 12 to SB 285. Voice vote was taken. Motion carried 7 to 6.

Motion: REP. SIMON withdrew the motion to adopt amendment 2 of amendment 12 to SB 285.

Discussion: REP. RICE presented and explained amendment 1 to SB 285. REP. RICE referred to the amendments as "anti-trust" amendments. The amendments would allow hospitals to enter into cooperative agreements.

Motion/Vote: REP. RICE moved to adopt amendment 1 to SB 285. EXHIBIT 11. Voice vote taken. Motion carried unanimously.

Two draft amendments were discussed but not voted on. EXHIBITS 12 and 13.

CHAIRMAN BOHARSKI said executive action on SB 285 would be continued on Monday at 3:00 p.m.

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING

COMMITTEE

ROLL CALL

DATE 3-26-93

NAME	PRESENT	ABSENT	EXCUSED
REP. BILL BOHARSKI, CHAIRMAN	✓		
REP. BRUCE SIMON, VICE CHAIRMAN	✓		
REP. STELLA JEAN HANSEN, V. CHAIR	✓		
REP. BEVERLY BARNHART			✓
REP. ELLEN BERGMAN	✓		
REP. JOHN BOHLINGER	✓		
REP. TIM DOWELL	✓		
REP. DUANE GRIMES	✓		
REP. BRAD MOLNAR	✓		
REP. TOM NELSON	✓		
REP. SHEILA RICE	✓		
REP. ANGELA RUSSELL	✓		
REP. TIM SAYLES	✓		
REP. LIZ SMITH	✓		
REP. CAROLYN SQUIRES	✓		
REP. BILL STRIZICH	✓		

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Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 20, line 22.
Strike: "By January 1, 1994, the"
Insert: "The"
2. Page 44, line 2.
Strike: "may"
Insert: "shall"
3. Page 45, line 13.
Strike: ". In"
Insert: "; in"
4. Page 45, line 21.
Strike: "."
Insert: ";
5. Page 46, lines 12 through 15.
Strike: subsection (e) in its entirety

Renumber: subsequent subsections
6. Page 47, line 6.
Strike: ". In"
Insert: "; in"
7. Page 47, line 14.
Strike: "."
Insert: "; and"
8. Page 48, line 10.
Strike: "may"
Insert: "shall"
9. Page 61, line 7.
Strike: "must have"
Insert: "has"

10. Page 61, line 12.

Strike: "must have the specific authority to"

Insert: "may"

11. Page 61, line 21.

Strike: "assessments"

Insert: "premiums"

12. Page 62, line 5.

Strike: "rules,"

Following: "conditions"

Strike: ", "

13. Page 64, line 8.

Strike: "business"

Insert: "health benefit plan"

14. Page 69, line 12.

Strike: "practitioner"

Insert: "practitioners"

15. Page 73, line 20.

Strike: "36"

Insert: "28, 35, and 36"

16. Page 73.

Following: line 21

Insert: "(4) [Sections 30 through 34] are effective July 1,
1993."

Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 36.

Following: line 7

Insert: "(3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group disability insurance, the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state."

Renumber: subsequent subsections

2. Page 59, line 18.

Following: "section]"

Insert: "and on or before March 1 of each year after that date"

Strike: "small employer carrier"

Insert: "assessable carrier"

3. Page 59, line 20.

Strike: "to small employers"

4. Page 61, line 2.

Strike: "reinsuring"

Insert: "assessable"

5. Page 62, line 13.

Strike: "and"

Insert: "(h) to the extent permitted by federal law and in accordance with subsection (11)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments that are reasonable and necessary for the expenses of organizing and operating the program; and"

Renumber: subsequent subsection

6. Page 66, lines 15 through 17.

Following: "(b)" on line 15

Strike: the remainder of line 15 through "." on line 17

Insert: "To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums

earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable carriers that are reasonable and necessary for the expenses of organizing the program and operating the program until the next fiscal yearend assessment. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed \$10."

7. Page 67.

Following: line 11

Insert: "(15) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation."

8. Page 73.

Following: line 15

Insert: "NEW SECTION. Section 38. {standard} Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent section

9. Page 73, line 17.

EXHIBIT 3
DATE 3/26/93
SB 285

Following: "37,"
Insert: "and 38"

EXHIBIT 4
3-26-93
285

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 48, lines 7 through 9.
Strike: subsection (j) in its entirety
- Renumber: subsequent subsection.

NOTE: This amendment strikes the prohibition against small group carriers using case characteristics other than age without the approval of the Commissioner of Insurance. Proposed by the Blues.

5
3-26-93
285

Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 69, line 12.

Strike: "does"

Insert: "and a law that requires the coverage of a health care service or benefit do"

2. Page 69, line 15.

Following: "through 26]"

Insert: "but do apply to a standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36]"

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 42, line 15.

Following: "taxation"

Insert: "or that are members of an association that has been in
existence for 1 year prior to [the effective date of
sections 22 through 36] and that provides a health benefit
plan to employees of its members as a group"

EXHIBIT 7
DATE 3-26-93
SB 285

Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 67.

Strike: lines 15 and 16

Insert: "the following members:

- (a) one health care provider;
- (b) one representative of the health insurance industry;
- (c) one employee of a small employer;
- (d) one member of a labor union; and
- (e) one representative of the general public who may not represent the persons or groups listed in subsections (1)(a) through (1)(d)."

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 26, line 12.
Following: "process for"
Insert: "hospitals and for"

NOTE: This amendment adds hospitals to the list of providers exempt from CON which the authority is to study to determine if that exemption should be continued

Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 33, line 3.

Following: "."

Insert: "Information in the data base not required by law to be
kept confidential must be made available by the authority
upon request of any person."

10
3-26-93
285

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 26, 1993

1. Page 15, line 1.
Following: "component"
Insert: ", including annual cost containment targets"
2. Page 15.
Strike: lines 2 through 8
3. Page 15, line 11.
Strike: "target"
Insert: "targets"
4. Page 16, line 6.
Strike: "target"
Insert: "targets"

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Sen. Towe
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 23, 1993

1. Title.

Page 2, line 9

Following: "ACT;"

Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO
COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF
THE AUTHORITY;"

2. Page 6.

Following: line 5

Insert: "(6) A statement of intent is also required for this
bill because [section 44] requires the authority to adopt
rules implementing [sections 37 through 44]. The rules
adopted by the authority must specify the form and content
of applications for certificates of public advantage;
details of the reconsideration, revocation, hearing, and
appeal processes; and such other matters as the authority
determines necessary. The rules adopted by the authority
must also provide the authority with direct supervision and
control over the implementation of cooperative agreements
between facilities."

3. Page 7, line 14.

Following: "20"

Insert: "and 37 through 44"

4. Page 7.

Following: line 18

Insert: "(3) \"Certificate of public advantage\" or \"certificate\"
means a written certificate issued by the authority as
evidence of the authority's intention that the
implementation of a cooperative agreement, when actively
supervised by the authority, receive state action immunity
from prosecution as a violation of state or federal
antitrust laws.

(4) \"Cooperative agreement\" or \"agreement\" means a written
agreement between two or more health care facilities for the
sharing, allocation, or referral of patients; personnel;
instructional programs; emergency medical services; support
services and facilities; medical, diagnostic, or laboratory

facilities or procedures; or other services customarily offered by health care facilities."

Renumber: subsequent subsections

5. Page 10.

Following: line 15

Insert: "(8) The attorney general is an ex officio, nonvoting member of the authority only for the purpose of the authority's approval or denial of certificates of public advantage, supervision of cooperative agreements, and revocation of certificates of public advantage pursuant to [sections 37 through 44]."

Renumber: subsequent subsection

6. Page 22, line 17.

Strike: "shall"

Insert: "may"

Following: "legislation"

Insert: "in addition to [sections 37 through 44]"

7. Page 73.

Following: line 8

Insert: "NEW SECTION. Section 37. Finding and purpose. The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of [sections 37 through 44] is to provide the state, through the authority, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws.

NEW SECTION. Section 38. Cooperative agreements allowed. A health care facility may enter into a cooperative agreement with one or more health care facilities.

NEW SECTION. Section 39. Certificate of public advantage - standards for certification -- time for action by authority.
(1) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed agreement, a description of the scope of the cooperation

contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The authority may not issue a certificate unless the authority finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the authority denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the authority not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The authority shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application. When considered necessary or appropriate by the authority, it may hold a public hearing on the application.

NEW SECTION. Section 40. Reconsideration by authority.

(1) If the authority denies an application and refuses to issue a certificate, a party to the agreement may request that the authority reconsider its decision. The authority shall reconsider its decision if the party applying for reconsideration submits the request to the authority in writing within 30 calendar days of the authority's decision to deny the initial application.

(2) The authority shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The authority shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the authority must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

NEW SECTION. Section 41. Revocation of certificate by authority. (1) The authority may revoke a certificate previously granted by it if the authority determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the authority without giving notice and an opportunity for a hearing before the authority as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the authority within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the authority shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the authority, the agreement for which the certificate was issued is terminated.

NEW SECTION. Section 42. Appeal. A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the authority to deny an application for a certificate or a decision by the authority to revoke a certificate. A revocation of a certificate pursuant to [section 41] does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

NEW SECTION. Section 43. Record of agreements to be kept. The authority shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to [section 37 through 44]. A party to a cooperative agreement who terminates the agreement shall notify the authority in writing of the termination within 30 days after the termination.

NEW SECTION. Section 44. Rulemaking. The authority shall adopt rules to implement [sections 37 through 43]. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by [sections 37 through 43], and appeals; and

(3) to effect the active supervision by the authority of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect."

Renumber: subsequent sections

8. Page 73, lines 10 and 12.

Following: "20"

Insert: "and 37 through 44"

9. Page 73, line 17.

Strike: "37,"

Insert: "44, and 45,"

MMA PROPOSED AMENDMENTS TO SENATE BILL 285

Page 13, Line 18

Following: {Section 5}

Insert: "should consider"

Strike: "must contain"

Page 15, Line 1

Following: "plans"

Insert: "should consider"

Strike: "must contain"

Page 15, Line 16

Following: "authority"

Insert: "may consider"

Strike: "shall include"

Page 16, Line 21

Following: "plan"

Insert: "should consider"

Strike: "must contain"

Page 20, Line 2

Following: "plan"

Insert: "should consider"

Strike: "must contain"

Page 21, Line 11

Following: "authority"

Insert: "should consider"

Strike: "must include"

March 19, 1993

Amendments to Senate Bill No. 285
(Re: Universal Health Care Access)
2nd Reading Copy

1. Page 7, line 10.
Following: ";"
Strike: "and"

Page 7, lines 12.
Following: "care"
Strike: "."
Insert: "; and"

Page 7.
Following: line 12
Insert: "(g) facilitate universal access to current health sciences information."

2. Page 14.
Following: line 3
Insert: "(f) consideration of state government funding limitations;"
Renummer: subsequent subsections

3. Page 15, line 16.
Following: "shall"
Insert: ", at a minimum,"

4. Page 17, line 19.
Following: ";"
Strike: "and"

Page 17, line 20.
Following: ";"
Insert: "and"

Page 17.
Following: line 20
Insert: "(x) health sciences library resources and services;"

5. Page 30, line 2.
Following: "from"
Strike: "local"
Insert: "public and private"
-end-

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By CHAIRMAN BILL BOHARSKI, on March 29, 1993, at
3:00 p.m.

ROLL CALL

Members Present:

Rep. Bill Boharski, Chairman (R)
Rep. Bruce Simon, Vice Chairman (R)
Rep. Stella Jean Hansen, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. Ellen Bergman (R)
Rep. John Bohlinger (R)
Rep. Tim Dowell (D)
Rep. Duane Grimes (R)
Rep. Tom Nelson (R)
Rep. Sheila Rice (D)
Rep. Angela Russell (D)
Rep. Tim Sayles (R)
Rep. Liz Smith (R)
Rep. Carolyn Squires (D)
Rep. Bill Strizich (D)

Members Excused:

Members Absent: Rep. Molnar

Staff Present: David Niss, Legislative Council
Alyce Rice, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: None
Executive Action: SB 285 cont'd.

EXECUTIVE ACTION ON SB 285 cont'd.

Discussion: REP. SIMON presented and explained amendment no. 14
to SB 285.

Motion/Vote: REP. SIMON moved to adopt amendment no. 14 to SB
285. EXHIBIT 1. Voice vote was taken. Motion carried
unanimously.

Discussion: CHAIRMAN BOHARSKI presented and explained amendment no. 15 to SB 285.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt amendment no. 15 to SB 285. EXHIBIT 2. Voice vote was taken. Motion carried unanimously.

Discussion: REP. SIMON presented and explained amendments 1 and 2 of amendment no. 16 to SB 285.

REP. RICE said she would like to vote on the amendments separately because amendment 1 of amendment no. 16 weakens the bill.

Motion/Vote: REP. SIMON moved to adopt amendment 2, of amendment 16 of SB 285. EXHIBIT 3. Voice vote was taken. Motion carried 15 to 1.

Discussion: REP. RICE said amendment no. 1 of amendment 16 weakens the bill because "must" is replaced by "consideration of the following matters" in section 6 of the bill, regarding guaranteed access to health care services for all residents of Montana and numerous other important features.

SEN. FRANKLIN said "consideration" is too limited. The mandate is that the plan must address those issues. SEN. FRANKLIN asked the committee to support the original language.

REP. SIMON said there are so many features the statewide plan must contain, that there is a possibility one of these features can't be addressed, yet it is mandated by law. By giving some flexibility in using "consideration" instead of "must," a plan can still be put together, even if there is a feature that can't be addressed.

The committee decided not to move to adopt amendment no. 1 of amendment 16, to SB 285.

REP. STRIZICH asked SEN. FRANKLIN if any of the features in the plan were impossible to address, to which she replied no.

Discussion: REP. SIMON presented amendment no. 17 to SB 285. David Niss, Legal Counsel explained the amendments.

Motion/Vote: REP. SIMON moved to adopt amendment no. 17. EXHIBIT 4. Voice vote was taken. Motion carried unanimously.

Discussion: CHAIRMAN BOHARSKI presented and explained amendment no. 18 to SB 285.

Motion/Vote: CHAIRMAN BOHARSKI moved to adopt amendment no. 18. Voice vote was taken. EXHIBIT 5. Motion carried unanimously.

Discussion: REP. SIMON presented and explained amendment no. 19

to SB 285.

Motion/Vote: REP. SIMON moved to adopt amendment no. 19.
EXHIBIT 6. Voice vote was taken. Motion carried unanimously.

Discussion: REP. SIMON presented and explained the Montana Medical Association's amendments 1 through 11, of amendment no. 20, to SB 285, but said he would not move to adopt them.

Motion/Vote: REP. SMITH moved to adopt amendment no. 20. EXHIBIT 7. Voice vote was taken. Motion failed 5 to 10.

Motion/Vote: REP. RUSSELL moved to adopt amendments 1 through 4 of amendment no. 22 to SB 285. EXHIBIT 8.

Discussion: REP. RUSSELL explained amendments 1 through 4 of amendment no. 22 to SB 285

CHAIRMAN BOHARSKI said the makeup of the committee in section 31 of the bill had been changed, and he didn't think amendment 4 would fit the changes. CHAIRMAN BOHARSKI suggested amendments 1 through 3 be voted on first.

Vote: Voice vote was taken. Motion carried unanimously.

Discussion:

REP. RICE suggested amendment no. 4 be discussed the during conference committee meeting. The committee agreed.

REP. RUSSELL withdrew her motion to adopt amendment 4 of amendment 22.

Motion/Vote: REP. SMITH moved to adopt amendments 1 through 11 of amendment no. 21. EXHIBIT 9. Voice vote was taken. Motion carried 12 to 3.

Motion/Vote: REP. SMITH moved to adopt amendments 12 and 13 of amendment no. 21. Voice vote was taken. Motion carried unanimously.

Motion/Vote: REP. RICE MOVED SB 285 BE CONCURRED IN AS AMENDED. Voice vote was taken. Motion carried unanimously.

REP. JIM RICE will carry SB 285.

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING

COMMITTEE

ROLL CALL

DATE 3-29-93

NAME	PRESENT	ABSENT	EXCUSED
REP. BILL BOHARSKI, CHAIRMAN	✓		
REP. BRUCE SIMON, VICE CHAIRMAN	✓		
REP. STELLA JEAN HANSEN, V. CHAIR	✓		
REP. BEVERLY BARNHART	✓		
REP. ELLEN BERGMAN	✓		
REP. JOHN BOHLINGER	✓		
REP. TIM DOWELL	✓		
REP. DUANE GRIMES	✓		
REP. BRAD MOLNAR		✓	
REP. TOM NELSON	✓		
REP. SHEILA RICE	✓		
REP. ANGELA RUSSELL	✓		
REP. TIM SAYLES	✓		
REP. LIZ SMITH	✓		
REP. CAROLYN SQUIRES	✓		
REP. BILL STRIZICH	✓		

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human services and Aging

Prepared by David S. Niss
March 27, 1993

1. Page 3, line 24
Following: "~~effective.~~"
Insert: "(1)"

2. Page 4, line 2.
Strike: "(1)"
Insert: "(a)"

3. Page 4, line 9.
Strike: "(2)"
Insert: "(b)"

4. Page 4, line 22.
Strike: "(3)"
Insert: "(c)"

5. Page 5, line 2.
Strike: "(4)"
Insert: "(d)"

6. Page 5, line 14.
Strike: "(5)"
Insert: "(e)"

7. Page 6.
Following: line 5
Insert: "(2) In preparing the plan required by [section 5], the
authority shall consider the following matters for the
following features of the plan:
(a) a unified health care budget. The authority shall
consider the development of a state health care budget based upon
the budgets submitted by the regional health care planning
boards.
(b) caps for provider expenditures. The authority
shall consider a process for adopting mandatory limits on
provider expenses, including fees and salaries.
(c) global budgeting for all health care spending.
The authority shall consider adopting a budgeting process, with

public involvement, by which a unified health care budget is determined.

(d) controlled capital expenditures. The authority shall consider adopting a system similar to the certificate of need system by which capital expenditures are controlled.

(e) binding cap on overall expenditures. The authority shall consider adopting mandatory limits on all types of expenditures of health care providers, including capital expenditures, small equipment purchases, personnel costs, and all other types of operating costs."

8. Page 7.

Following: line 12

Insert: "(3) It is further the policy of the state of Montana that regardless of whether or what form of a health care access plan is adopted by the legislature, the health care authority, health care providers, and other persons involved in the delivery of health care services need to increase their emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only services to the consumer that are reasonable and necessary."

Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
March 29, 1993

1. Page 7.
Following: line 8
Insert: "(e) facilitate universal access to health sciences
information"

Renumber: subsequent subsections

2. Page 14.
Following: line 3
Insert: "(f) consideration of the limitations of public funding"

Renumber: subsequent subsections

3. Page 15, line 16.
Following: "shall"
Insert: ", at a minimum,"

4. Page 17.
Following: line 18
Insert: "(viii) health sciences library resources and services;"

Renumber: subsequent subsections

5. Page 30, line 2.
Strike: "local"
Insert: "public and private"

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 27, 1993

1. Page 13, line 21.

Following: "include"

Insert: "consideration of the following matters"

2. Page 14.

Following: line 24

Insert: "(3) Nothing in [sections 7 through 9 and 11] or this
section may be interpreted to prevent Montana residents from
seeking health care services not provided in either or both
statewide plans."

Amendments to House Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human services and Aging

Prepared by David S. Niss
March 29, 1993

1. Page 5, line 14.

Following: "30,"

Insert: "31,"

2. Page 67, line 17.

Following: "shall"

Insert: ", after holding a public hearing,"

3. Page 68, line 18.

Strike: "for approval"

4. Page 68, line 19.

Following: "committee."

Insert: "The commissioner shall adopt as a rule pursuant to Title
2, chapter 4, part 3, the health benefit plans required by
[section 29(1)] to be offered in this state."

Amendments to Senate Bill No. 285
Third Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
March 27, 1993

1. Page 11, line 22.
Strike: "and perform other acts"

EXHIBIT 6
DATE 3-29-93
SB 285

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 29, 1993

1. Page 9, lines 8 and 10."

Strike: "majority"

Insert: "speaker"

2. Page 9, lines 15 and 17.

Strike: "majority"

Insert: "president"

3. Page 12, lines 22 and 23.

Strike: "no later than 45 days from the first day of the 1995
legislative session"

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Simon
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 29, 1993

1. Page 13, line 18.

Strike: "Each"

Insert: "In preparing each "

Strike: "must contain"

Insert: ", the authority shall consider including"

2. Page 13, line 19.

Following: "required"

Strike: "by"

Insert: "to be considered under"

3. Page 13, line 21.

Strike: "Each statewide plan must include"

Insert: "The authority shall consider including the following
features in each statewide plan"

4. Page 15, line 1.

Strike: "statewide plans must contain a cost containment
component"

Insert: "authority shall consider including a cost containment
component in each statewide plan"

5. Page 15, line 3.

Strike: "must"

Insert: "may"

6. Page 15, lines 9 and 16.

Strike: "shall"

Insert: "may"

7. Page 16, line 21.

Strike: "Each statewide plan must contain"

Insert: "In preparing each statewide plan, the authority shall
consider including"

8. Page 16, line 23, and page 17, line 3.

Strike: "must"

Insert: "may"

9. Page 20, line 2.

Strike: "Each statewide plan must contain"

Insert: "In preparing each statewide plan, the authority shall consider including"

10. Page 20, lines 12 and 16.

Strike: "must"

Insert: "may"

11. Page 21, lines 10 and 11.

Strike: "The statewide plans recommended by the authority must include"

Insert: "In preparing each statewide plan, the authority shall consider including the following matters in each plan"

EXHIBIT 8
DATE 3-29-93
SB 285

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Russell
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 29, 1993

1. Page 7.

Following: line 20

Insert: "(4) "Health care" includes both physical health care
and mental health care."

Renumber: subsequent subsections

2. Page 13, lines 2 and 9.

Following: "health"

Insert: "care"

3. Page 38, line 25.

Following: "certificate"

Insert: "providing for physical and mental health care"

4. Page 67, line 15.

Following: "employees,"

Insert: "physical and mental"

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Rep. Smith
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 29, 1993

1. Page 3, line 24
Following: "~~effective.~~"
Insert: "(1)"

2. Page 4, line 2.
Strike: "(1)"
Insert: "(a)"

3. Page 4, line 9.
Strike: "(2)"
Insert: "(b)"

4. Page 4, line 22.
Strike: "(3)"
Insert: "(c)"

5. Page 5, line 2.
Strike: "(4)"
Insert: "(d)"

6. Page 5, line 14.
Strike: "(5)"
Insert: "(e)"

7. Page 6.
Following: line 5
Insert: "(2) In preparing the plan required by [section 5], the authority shall consider market control. The authority shall consider the development of a state health care plan based upon the preferences and needs of the health care consumer. Incentives for market control should include mechanisms that encourage health care providers to respond to preferences and needs of health care consumers."

8. Page 12, line 17.
Following: "system."
Insert: "Each statewide plan must include incentives for market control."

9. Page 14, line 10.

Following: "costs"

Insert: ", provide market control,"

10. Page 14.

Following: line 17

Insert: "(o) incentives for market control;"

Renumber: subsequent subsections

11. Page 15, line 23.

Following: "prognosis"

Insert: "and an individual's choice of services"

12. Page 23, line 6.

Strike: "Hearings"

Insert: "Availability of plans -- hearings"

Following: "plans."

Insert: "(1) The authority shall make copies of the draft
statewide plans widely available at public expense to
interested persons and groups. (2)"

13. Page 23.

Following: line 17

Insert: "(3) The authority shall consider oral and written
public comments on the statewide plans before recommending
them to the legislature."

March 30, 1993

Page 1 of 14

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 285 (third reading copy -- blue) be concurred in as amended.

Signed: Wm E Boharski
Bill Boharski, Chair

And, that such amendments read: Carried by: Rep. Jim Rice

1. Title.
Page 2, line 9
Following: "ACT;"
Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY;"

2. Page 3, line 24
Following: "effective."
Insert: "(1)"

3. Page 4, line 2.
Strike: "(1)"
Insert: "(a)"

4. Page 4, line 9.
Strike: "(2)"
Insert: "(b)"

5. Page 4, line 22.
Strike: "(3)"
Insert: "(c)"

6. Page 5, line 2.
Strike: "(4)"
Insert: "(d)"

7. Page 5, line 14.
Strike: "(5)"
Insert: "(e)"
Following: "30,"
Insert: "31,"

Committee Vote:
Yes 15, No 0.

710952SC.Hss

8. Page 6.

Following: line 5

Insert: "(f) [section 44] requires the authority to adopt rules implementing [sections 37 through 44]. The rules adopted by the authority must specify the form and content of applications for certificates of public advantage; details of the reconsideration, revocation, hearing, and appeal processes; and other matters as the authority determines necessary. The rules that are adopted by the authority must also provide the authority with direct supervision and control over the implementation of cooperative agreements between facilities.

(2) In preparing the plan required by [section 5], the authority shall consider the following matters for the following features of the plan:

(a) a unified health care budget. The authority shall consider the development of a state health care budget based upon the budgets submitted by the regional health care planning boards.

(b) caps for provider expenditures. The authority shall consider a process for adopting mandatory limits on provider expenses, including fees and salaries.

(c) global budgeting for all health care spending. The authority shall consider adopting a budgeting process, with public involvement, by which a unified health care budget is determined.

(d) controlled capital expenditures. The authority shall consider adopting a system similar to the certificate of need system by which capital expenditures are controlled.

(e) binding cap on overall expenditures. The authority shall consider adopting mandatory limits on all types of expenditures of health care providers, including capital expenditures, small equipment purchases, personnel costs, and all other types of operating costs.

(f) market control. The authority shall consider the development of a state health care plan based upon the preferences and needs of the health care consumer. Incentives for market control should include mechanisms that encourage health care providers to respond to preferences and needs of health care consumers."

9. Page 7.

Following: line 8

Insert: "(e) facilitate universal access to health sciences information;"

Renumber: subsequent subsections

HOUSE
5B 285

10. Page 7.

Following: line 12

Insert: "(3) It is further the policy of the state of Montana that regardless of whether or what form of a health care access plan is adopted by the legislature, the health care authority, health care providers, and other persons involved in the delivery of health care services need to increase their emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only services to the consumer that are reasonable and necessary."

11. Page 7, line 14.

Following: "20"

Insert: "and 37 through 44"

12. Page 7.

Following: line 18

Insert: "(3) 'Certificate of public advantage' or 'certificate' means a written certificate issued by the authority as evidence of the authority's intention that the implementation of a cooperative agreement, when actively supervised by the authority, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(4) 'Cooperative agreement' or 'agreement' means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities."

Renumber: subsequent subsections

13. Page 7.

Following: line 20

Insert: "(6) 'Health care' includes both physical health care and mental health care."

Renumber: subsequent subsections

14. Page 9, lines 8 and 10.

Strike: "majority"

Insert: "speaker"

15. Page 9, lines 15 and 17.

Strike: "majority"

Insert: "president"

16. Page 10.

Following: line 15

Insert: "(8) The attorney general is an ex officio, nonvoting member of the authority only for the purpose of the authority's approval or denial of certificates of public advantage, supervision of cooperative agreements, and revocation of certificates of public advantage pursuant to [sections 37 through 44]."

Renumber: subsequent subsection

17. Page 11, line 22.

Strike: "and perform other acts"

18. Page 12, line 17.

Following: "system."

Insert: "Each statewide plan must include incentives for market control."

19. Page 12, lines 22 and 23.

Strike: "no later than 45 days from the first day of the 1995 legislative session"

20. Page 13, lines 2 and 9.

Following: "health"

Insert: "care"

21. Page 14.

Following: line 3

Insert: "(f) consideration of the limitations of public funding;"

Renumber: subsequent subsections

22. Page 14, line 10.
Following: "costs"
Insert: ", provide market control,"

23. Page 14.
Following: line 17
Insert: "(p) incentives for market control;"

Renumber: subsequent subsections

24. Page 14.
Following: line 24
Insert: "(3) Nothing in [sections 7 through 9 and 11] or this section may be interpreted to prevent Montana residents from seeking health care services not provided in either or both statewide plans."

25. Page 15, line 1.
Following: "component"
Insert: ", including annual cost containment targets"

26. Page 15, line 3.
Strike: "a target"
Insert: "targets"

27. Page 15, line 11.
Strike: "target"
Insert: "targets"

28. Page 15, line 16.
Following: "shall"
Insert: ", at a minimum,"

29. Page 15, line 23.
Following: "prognosis"
Insert: "and an individual's choice of services"

30. Page 16, line 6.
Strike: "target"
Insert: "targets"

31. Page 17.
Following: line 18
Insert: "(viii) health sciences library resources and services;"

Renumber: subsequent subsections

32. Page 20, line 22.
Strike: "By January 1, 1994, the"
Insert: "The"

33. Page 22, line 17.
Strike: "shall"
Insert: "may"
Following: "legislation"
Insert: "in addition to [sections 37 through 44]"

34. Page 23, line 6.
Strike: "Hearings"
Insert: "Availability of plans -- hearings"
Following: "plans."
Insert: "(1) The authority shall make copies of the draft statewide plans widely available at public expense to interested persons and groups. (2)"

35. Page 23.
Following: line 17
Insert: "(3) The authority shall consider oral and written public comments on the statewide plans before recommending them to the legislature."

36. Page 26, line 12.
Following: "process for"
Insert: "hospitals and for"

37. Page 30, line 2.
Strike: "local"
Insert: "public and private"

38. Page 33, line 3.
Following: ". "
Insert: "Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person."

39. Page 36.
Following: line 7

Insert: "(3) 'Assessable carrier' means all individual carriers of disability insurance and all carriers of group disability insurance, the state group benefits plan provided for in Title 2, Chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state."

Renumber: subsequent subsections

40. Page 38, line 25.

Following: "certificate"

Insert: "providing for physical and mental health care"

41. Page 42, line 15.

Following: "taxation"

Insert: "or that are members of an association that has been in existence for 1 year prior to [the effective date of sections 22 through 36] and that provides a health benefit plan to employees of its members as a group"

42. Page 44, line 2.

Strike: "may"

Insert: "shall"

43. Page 45, line 13.

Strike: ". In"

Insert: "; in"

44. Page 45, line 21.

Strike: "."

Insert: ";

45. Page 46, lines 12 through 15.

Strike: subsection (e) in its entirety

Renumber: subsequent subsections

46. Page 47, line 6.

Strike: ". In"

Insert: "; in"

47. Page 47, line 14.

Strike: "."

Insert: "; and"

48. Page 48, lines 7 through 9.

Strike: subsection (j) in its entirety

Renumber: subsequent subsection

49. Page 48, line 10.

Strike: "may"

Insert: "shall"

50. Page 59, line 18.

Following: "section]"

Insert: "and on or before March 1 of each year after that date"

Strike: "small employer"

Insert: "assessable"

51. Page 59, line 20.

Strike: "to small employers"

52. Page 61, line 2.

Strike: "reinsuring"

Insert: "assessable"

53. Page 61, lines 2 and 3.

Strike: "and administrative expenses"

54. Page 61, line 3.

Strike: "or estimated to be incurred"

55. Page 61, line 4.

Strike: "and"

Insert: "(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and"

Renumber: subsequent subsection

56. Page 61, line 7.

Strike: "must have"

Insert: "has"

57. Page 61, line 12.

Strike: "must have the specific authority to"

Insert: "may"

58. Page 61, line 21.

Strike: "assessments"

Insert: "premiums"

59. Page 62, line 5.

Strike: "rules,"

Following: "conditions"

Strike: ", "

60. Page 62, line 13.

Strike: "and"

Insert: "(h) to the extent permitted by federal law and in accordance with subsection (11)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and"

Renumber: subsequent subsection

61. Page 64, line 8.

Strike: "business"

Insert: "health benefit plan"

62. Page 66, lines 15 through 17.

Following: "(b)" on line 15

Strike: the remainder of line 15 through "." on line 17

Insert: "To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable

carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed \$10."

63. Page 67.

Following: line 11

Insert: "(15) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation."

64. Page 67.

Strike: lines 15 and 16

Insert: "the following members:

- (a) one health care provider;
- (b) one representative of the health insurance industry;
- (c) one employee of a small employer;
- (d) one member of a labor union; and
- (e) one representative of the general public who may not represent the persons or groups listed in subsections (1)(a) through (1)(d)."

65. Page 67, line 17.

Following: "shall"

Insert: ", after holding a public hearing,"

66. Page 68, line 18.

Strike: "for approval"

67. Page 68, line 19.

Following: "committee."

Insert: "The commissioner shall adopt as a rule pursuant to Title 2, chapter 4, part 3, the health benefit plans required by [section 29(1)] to be offered in this state."

68. Page 69, line 12.

Strike: "practitioner does"

Insert: "practitioners and a law that requires the coverage of a health care service or benefit do"

69. Page 69, line 15.

Following: "through 36]"

Insert: "but do apply to a standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36]"

70. Page 73.

Following: line 8

Insert: "NEW SECTION. Section 37. Finding and purpose. The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of [sections 37 through 44] is to provide the state, through the authority, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws."

NEW SECTION. Section 38. Cooperative agreements allowed. A health care facility may enter into a cooperative agreement with one or more health care facilities.

NEW SECTION. Section 39. Certificate of public advantage -- standards for certification -- time for action by authority.

(1) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed

agreement, a description of the scope of the cooperation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The authority shall hold a public hearing on the application for a certificate before acting upon the application. The authority may not issue a certificate unless the authority finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the authority denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the authority not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The authority shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application.

NEW SECTION. Section 40. Reconsideration by authority.

(1) If the authority denies an application and refuses to issue a certificate, a party to the agreement may request that the authority reconsider its decision. The authority shall reconsider its decision if the party applying for reconsideration submits the request to the authority in writing within 30 calendar days of the authority's decision to deny the initial application.

(2) The authority shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The authority shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the authority must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

NEW SECTION. Section 41. Revocation of certificate by authority. (1) The authority shall revoke a certificate previously granted by it if the authority determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the authority without giving notice and an opportunity for a hearing before the authority as follows:

(a) Written notice of the proposed revocation must be given

to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the authority within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the authority shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the authority, the agreement for which the certificate was issued is terminated.

NEW SECTION. Section 42. Appeal. A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the authority to deny an application for a certificate or a decision by the authority to revoke a certificate. A revocation of a certificate pursuant to [section 41] does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

NEW SECTION. Section 43. Record of agreements to be kept. The authority shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to [section 37 through 44]. A party to a cooperative agreement who terminates the agreement shall notify the authority in writing of the termination within 30 days after the termination.

NEW SECTION. Section 44. Rulemaking. The authority shall adopt rules to implement [sections 37 through 43]. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by [sections 37 through 43], and appeals; and

(3) to effect the active supervision by the authority of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for

which a certificate is in effect."

Renumber: subsequent sections

71. Page 73, lines 10 and 12.

Following: "20"

Insert: "and 37 through 44"

72. Page 73.

Following: line 15

Insert: "NEW SECTION. Section 46. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent section

73. Page 73, line 17.

Strike: ", 37,"

Insert: "and 44 through 46"

74. Page 73, line 20.

Following: "through"

Insert: "28, 35, and"

75. Page 73.

Following: line 21

Insert: "(4) [Sections 30 through 34] are effective July 1, 1993."

-END-

3-30-93
10/14

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
 BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN,
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 PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN,
 WELDON, KENNEDY, WILSON, BARTLETT,
 SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST
 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
 REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON
 LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH
 PLANNING REGIONS AND BOARDS REQUIRING DEVELOPMENT OF UNIFORM
CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO
CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM
CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
UNIFIED HEALTH CARE DATA BASE; PROVIDING---FOR---HEALTH
INSURANCE---REPORT REQUIRING HEALTH INSURER COST MANAGEMENT
PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
SCIENCES RELATING TO VITAL-STATISTICS STATE HEALTH PLANNING;
PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
ACT; ALLOWING HEALTH CARE FACILITIES TO ENTER INTO
COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF
THE AUTHORITY; AMENDING SECTION 50-15-101 50-1-201, MCA; AND
PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A--statement--of--legislative--intent--is--required--for--this
 bill--because--{section--10}--requires--the--Montana--health--care
 authority--to--adopt--rules--establishing--a--maximum--of--five
 health--care--planning--regions--to--establish--regional--health
 care--planning--boards--within--those--regions--and--to--establish
 a--procedure--for--selection--of--regional--board--members--The
 legislature--intends--that--the--rules--establishing--the--health
 care--planning--regions--be--based--primarily--upon--the--geographic
 health--care--referral--patterns--by--which--health--care--providers
 refer--patients--to--specialists--or--larger--health--care
 facilities--These--rules--should--also--consider--communication

and-transportation-patterns-and-natural--barriers--to--these
patterns.-The-rules-establishing-the-boards-must-specify-the
number--of--members,-any--relevant--qualifications,-and-the
operations-and-duties-of-the-boards-and-must-provide--for--a
funding-mechanism-by-grant-from-the-authority.-The-procedure
for--selection--of-the-board-members-must-provide-for-public
notice-of-the-selection-process.

A-statement-of-intent-is-also-required-because--(section
12)--requires--the--authority-to-adopt-rules-relating-to-the
unified-health-care-data-base.-The--authority's--rules--must
specify-in-comprehensive-detail-what-information-is-required
to--be--provided--by--health-care-providers-and-the-times-at
which-the-information-is-to-be-provided.-The-rules-must-also
provide-for-audit-procedures-to-determine--the--accuracy--of
the--filed--data.-The--confidentiality--provisions--must-be
consistent---with---other---state---laws---governing---the
confidentiality---of---public---records,-including--medical
records,-and-must-apply-to-employees-of-the-authority-and-to
others-receiving-or-using-records-in-the-data-base.

A-statement-of-intent-is-also-required-because--(section
13)--requires--the--commissioner-of-insurance-to-adopt-rules
governing-small-employer-group-health-plans,-in--determining
the--basic--benefits--package,-the--commissioner-shall-make
objective--determinations,-supported--by--available---data,
concerning-the-type-of-benefits-required-and-shall-determine

that--the--benefits-to-be-required-are-cost-effective. (1) A
STATEMENT OF LEGISLATIVE INTENT IS REQUIRED FOR THIS BILL
BECAUSE:

(1)(A) [SECTION 4] AUTHORIZES THE MONTANA HEALTH CARE
AUTHORITY TO ADOPT RULES NECESSARY TO IMPLEMENT [SECTIONS 1
THROUGH 20]. IN ADDITION TO THOSE RULEMAKING MATTERS
ADDRESSED BELOW, THE AUTHORITY MAY ADOPT RULES GOVERNING
SUCH MATTERS AS ITS MEETINGS, PUBLIC HEARINGS, AND RULES OF
PROCEDURE AND RULES OF ETHICAL CONDUCT GOVERNING ITS
MEMBERS.

(2)(B) [SECTION 17] REQUIRES THE MONTANA HEALTH CARE
AUTHORITY TO ADOPT RULES TO ESTABLISH REGIONAL HEALTH CARE
PLANNING BOARDS WITHIN THE HEALTH CARE PLANNING REGIONS
ESTABLISHED IN [SECTION 17] AND TO ESTABLISH A PROCEDURE FOR
SELECTION OF REGIONAL BOARD MEMBERS. THE RULES ESTABLISHING
THE BOARDS MUST SPECIFY THE NUMBER OF MEMBERS, ANY RELEVANT
QUALIFICATIONS, AND THE OPERATIONS AND DUTIES OF THE BOARDS
AND MUST PROVIDE FOR A FUNDING MECHANISM BY GRANT FROM THE
AUTHORITY. IN ADDITION, THE RULES MUST PROVIDE FOR
CONSIDERATION OF A BALANCE BETWEEN RURAL AND URBAN INTERESTS
IN THE SELECTION OF REGIONAL BOARD MEMBERS. THE PROCEDURE
FOR SELECTION OF THE BOARD MEMBERS MUST PROVIDE FOR PUBLIC
NOTICE OF THE SELECTION PROCESS.

(3)(C) [SECTION 10] GRANTS THE COMMISSIONER OF
INSURANCE THE AUTHORITY TO ADOPT RULES SPECIFYING UNIFORM

1 HEALTH INSURANCE CLAIM FORMS AND PROCEDURES. THE FORMS
 2 SHOULD BE BASED UPON EXISTING FORMATS, BE AS SHORT AS
 3 POSSIBLE, AND BE COMPATIBLE WITH ELECTRONIC DATA
 4 TRANSMISSION.

5 (4)(D) [SECTION 19] REQUIRES THE AUTHORITY TO ADOPT
 6 RULES RELATING TO THE UNIFIED HEALTH CARE DATA BASE. THE
 7 AUTHORITY'S RULES MUST SPECIFY IN COMPREHENSIVE DETAIL WHAT
 8 INFORMATION IS REQUIRED TO BE PROVIDED BY HEALTH CARE
 9 PROVIDERS AND THE TIMES AT WHICH THE INFORMATION IS TO BE
 10 PROVIDED. THE RULES MUST ALSO PROVIDE FOR AUDIT PROCEDURES
 11 TO DETERMINE THE ACCURACY OF THE FILED DATA. THE
 12 CONFIDENTIALITY PROVISIONS MUST BE CONSISTENT WITH OTHER
 13 STATE LAWS GOVERNING THE CONFIDENTIALITY OF PUBLIC RECORDS,
 14 INCLUDING MEDICAL RECORDS, AND MUST APPLY TO EMPLOYEES OF
 15 THE AUTHORITY AND TO OTHERS RECEIVING OR USING RECORDS IN
 16 THE DATA BASE.

17 (5)(E) [SECTIONS 23, 26, 27, 30, 31, AND 34 THROUGH 36]
 18 REQUIRE THE COMMISSIONER OF INSURANCE TO ADOPT RULES
 19 GOVERNING SMALL EMPLOYER GROUP HEALTH PLANS. IN DETERMINING
 20 THE BASIC BENEFITS PACKAGE, THE COMMISSIONER SHALL MAKE
 21 OBJECTIVE DETERMINATIONS, SUPPORTED BY AVAILABLE DATA,
 22 CONCERNING THE TYPE OF BENEFITS REQUIRED AND SHALL DETERMINE
 23 THAT THE BENEFITS TO BE REQUIRED ARE COST-EFFECTIVE PURSUANT
 24 TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE
 25 COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION

1 PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH
 2 CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE
 3 THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY
 4 IF THE COMMISSIONER DETERMINES THAT THE ADDITIONAL CLASSES
 5 WOULD ENHANCE THE EFFICIENCY AND FAIRNESS OF THE SMALL
 6 EMPLOYER HEALTH INSURANCE MARKET. THE COMMISSIONER IS
 7 REQUIRED UNDER THE ACT TO ADOPT RULES TO IMPLEMENT AND
 8 ADMINISTER THE ACT.

9 (F) [SECTION 44] REQUIRES THE AUTHORITY TO ADOPT RULES
 10 IMPLEMENTING [SECTIONS 37 THROUGH 44]. THE RULES ADOPTED BY
 11 THE AUTHORITY MUST SPECIFY THE FORM AND CONTENT OF
 12 APPLICATIONS FOR CERTIFICATES OF PUBLIC ADVANTAGE; DETAILS
 13 OF THE RECONSIDERATION, REVOCATION, HEARING, AND APPEAL
 14 PROCESSES; AND OTHER MATTERS AS THE AUTHORITY DETERMINES
 15 NECESSARY. THE RULES THAT ARE ADOPTED BY THE AUTHORITY MUST
 16 ALSO PROVIDE THE AUTHORITY WITH DIRECT SUPERVISION AND
 17 CONTROL OVER THE IMPLEMENTATION OF COOPERATIVE AGREEMENTS
 18 BETWEEN FACILITIES.

19 (2) IN PREPARING THE PLAN REQUIRED BY [SECTION 5], THE
 20 AUTHORITY SHALL CONSIDER THE FOLLOWING MATTERS FOR THE
 21 FOLLOWING FEATURES OF THE PLAN:

22 (A) A UNIFIED HEALTH CARE BUDGET. THE AUTHORITY SHALL
 23 CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE BUDGET BASED
 24 UPON THE BUDGETS SUBMITTED BY THE REGIONAL HEALTH CARE
 25 PLANNING BOARDS.

(B) CAPS FOR PROVIDER EXPENDITURES. THE AUTHORITY SHALL CONSIDER A PROCESS FOR ADOPTING MANDATORY LIMITS ON PROVIDER EXPENSES, INCLUDING FEES AND SALARIES.

(C) GLOBAL BUDGETING FOR ALL HEALTH CARE SPENDING. THE AUTHORITY SHALL CONSIDER ADOPTING A BUDGETING PROCESS, WITH PUBLIC INVOLVEMENT, BY WHICH A UNIFIED HEALTH CARE BUDGET IS DETERMINED.

(D) CONTROLLED CAPITAL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING A SYSTEM SIMILAR TO THE CERTIFICATE OF NEED SYSTEM BY WHICH CAPITAL EXPENDITURES ARE CONTROLLED.

(E) BINDING CAP ON OVERALL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING MANDATORY LIMITS ON ALL TYPES OF EXPENDITURES OF HEALTH CARE PROVIDERS, INCLUDING CAPITAL EXPENDITURES, SMALL EQUIPMENT PURCHASES, PERSONNEL COSTS, AND ALL OTHER TYPES OF OPERATING COSTS.

(F) MARKET CONTROL. THE AUTHORITY SHALL CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE PLAN BASED UPON THE PREFERENCES AND NEEDS OF THE HEALTH CARE CONSUMER. INCENTIVES FOR MARKET CONTROL SHOULD INCLUDE MECHANISMS THAT ENCOURAGE HEALTH CARE PROVIDERS TO RESPOND TO PREFERENCES AND NEEDS OF HEALTH CARE CONSUMERS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

(Refer to Introduced Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. Section 1. State health care policy. (1)

It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health care resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(E) FACILITATE UNIVERSAL ACCESS TO HEALTH SCIENCES

INFORMATION;

(F) PROMOTE RATIONAL ALLOCATION OF HEALTH CARE RESOURCES IN THE STATE; AND

(G) FACILITATE UNIVERSAL ACCESS TO PREVENTIVE AND MEDICALLY NECESSARY HEALTH CARE.

(3) IT IS FURTHER THE POLICY OF THE STATE OF MONTANA THAT REGARDLESS OF WHETHER OR WHAT FORM OF A HEALTH CARE ACCESS PLAN IS ADOPTED BY THE LEGISLATURE, THE HEALTH CARE AUTHORITY, HEALTH CARE PROVIDERS, AND OTHER PERSONS INVOLVED IN THE DELIVERY OF HEALTH CARE SERVICES NEED TO INCREASE THEIR EMPHASIS ON THE EDUCATION OF CONSUMERS OF HEALTH CARE SERVICES. CONSUMERS SHOULD BE EDUCATED CONCERNING THE HEALTH CARE SYSTEM, PAYMENT FOR SERVICES, ULTIMATE COSTS OF HEALTH CARE SERVICES, AND THE BENEFIT TO CONSUMERS GENERALLY OF PROVIDING ONLY SERVICES TO THE CONSUMER THAT ARE REASONABLE AND NECESSARY.

NEW SECTION. Section 2. Definitions. For the purposes of [sections 1 through 20 AND 37 THROUGH 44], the following definitions apply:

(1) "Authority" means the Montana health care authority created by [section 3].

(2) "Board" means one of the regional health care planning boards created pursuant to [section 17].

(3) "CERTIFICATE OF PUBLIC ADVANTAGE" OR "CERTIFICATE" MEANS A WRITTEN CERTIFICATE ISSUED BY THE AUTHORITY AS

EVIDENCE OF THE AUTHORITY'S INTENTION THAT THE IMPLEMENTATION OF A COOPERATIVE AGREEMENT, WHEN ACTIVELY SUPERVISED BY THE AUTHORITY, RECEIVE STATE ACTION IMMUNITY FROM PROSECUTION AS A VIOLATION OF STATE OR FEDERAL ANTITRUST LAWS.

(4) "COOPERATIVE AGREEMENT" OR "AGREEMENT" MEANS A WRITTEN AGREEMENT BETWEEN TWO OR MORE HEALTH CARE FACILITIES FOR THE SHARING, ALLOCATION, OR REFERRAL OF PATIENTS; PERSONNEL; INSTRUCTIONAL PROGRAMS; EMERGENCY MEDICAL SERVICES; SUPPORT SERVICES AND FACILITIES; MEDICAL, DIAGNOSTIC, OR LABORATORY FACILITIES OR PROCEDURES; OR OTHER SERVICES CUSTOMARILY OFFERED BY HEALTH CARE FACILITIES.

(5) "Data base" means the unified health care data base created pursuant to [section 19].

(6) "HEALTH CARE" INCLUDES BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

(7) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(8) "Health insurer" means any health insurance

company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

(6)(9) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(7)(10) "Management plan" means the health care resource management plan required by [section 8].

(8)(11) "Region" means one of the health care planning regions created pursuant to [section 17].

(9)(12) "Statewide plan" means one of the statewide universal health care access plans for access to health care required by [section 5].

NEW SECTION. Section 3. Montana health care authority
-- allocation -- **membership.** (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members appointed by the governor. At least one member must

represent consumer organizations. Members of the authority must be appointed as follows:

(a) Within 30 days of [the effective date of this section], the **majority SPEAKER** and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The **majority SPEAKER** and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(b) Within 30 days of [the effective date of this section], the **majority PRESIDENT** and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The **majority PRESIDENT** and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) THE ATTORNEY GENERAL IS AN EX OFFICIO, NONVOTING MEMBER OF THE AUTHORITY ONLY FOR THE PURPOSE OF THE AUTHORITY'S APPROVAL OR DENIAL OF CERTIFICATES OF PUBLIC ADVANTAGE, SUPERVISION OF COOPERATIVE AGREEMENTS, AND REVOCATION OF CERTIFICATES OF PUBLIC ADVANTAGE PURSUANT TO [SECTIONS 37 THROUGH 44].

~~(8)~~(9) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

NEW SECTION. Section 4. Administration of health care authority -- reports -- compensation. (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The executive director is exempt from the application of

2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with 50-1-201 and [sections 1 through 20];

(b) adopt rules necessary to implement [sections 1 through 20]; and

(c) enter into contracts ~~and--perform---other---acts~~ necessary to accomplish the purposes of [sections 1 through

1 20].

2 (5) The authority shall report to the legislature and
3 the governor at least twice a year on its progress since the
4 last report in fulfilling the requirements of [sections 1
5 through 20]. Reports may be provided in a manner similar to
6 5-11-210 or in another manner determined by the authority.

7 (6) Members of the authority must be paid and
8 reimbursed as provided in 2-15-124.

9 (7) The authority shall make grants to the boards for
10 the operation of the boards. The authority shall provide for
11 uniform procedures for grant applications and budgets of the
12 boards.

13 NEW SECTION. Section 5. Statewide universal access
14 plans required. (1) On or before October 1, 1994, the
15 authority shall submit a report to the legislature that
16 contains the authority's recommendation for a statewide
17 universal health care access plan based on a single payor
18 system and a recommendation for a statewide universal access
19 plan based on a regulated multiple payor system. EACH
20 STATEWIDE PLAN MUST INCLUDE INCENTIVES FOR MARKET CONTROL.
21 Each statewide plan must contain recommendations that, if
22 implemented, would provide for universally accessible,
23 medically necessary, and preventive health care by October
24 1, 1995. Both plans must be voted on by the 1995 legislature
25 no-later-than-45--days--from--the--first--day--of--the--1995

1 ~~legislative--session.~~ The legislature may return one or both
2 plans to the authority for further development.

3 (2) For purposes of this section:

4 (a) a single payor system is a method of financing
5 health CARE services predominantly through public funds so
6 that each resident of Montana receives a uniform set of
7 benefits as established through statute or administrative
8 rule. Policies governing all aspects of the management of
9 the single payor system would reside with state government,
10 and benefits must be administered by a single entity.

11 (b) a regulated multiple payor system is a method of
12 financing health CARE services through a mix of public and
13 private funds so that each resident of Montana receives a
14 uniform set of benefits as established by statute or
15 administrative rule. State government has responsibility for
16 regulating the multiple entities that provide benefits to
17 residents, including regulations for enrollment, change in
18 premium rates, payment rates to providers, and aggregate
19 health expenditures.

20 NEW SECTION. Section 6. Features of statewide plans.

21 (1) Each statewide plan under [section 5] must contain the
22 features required by [sections 7 through 9 and 11] and this
23 section.

24 (2) Each statewide plan must include:

25 (a) guaranteed access to health care services for all

1 residents of Montana;

2 (b) a uniform system of health care benefits;

3 (c) a unified health care budget;

4 (d) portability of coverage, regardless of job status;

5 (e) a broad-based, public or private financing

6 mechanism to fund health care services;

7 (F) CONSIDERATION OF THE LIMITATIONS OF PUBLIC FUNDING;

8 ~~(f)~~(G) a system capped for provider expenditures;

9 ~~(g)~~(H) global budgeting for all health care spending;

10 ~~(h)~~(I) controlled capital expenditures;

11 ~~(i)~~(J) a binding cap on overall expenditures;

12 ~~(j)~~(K) policymaking for the system as a whole and

13 accountability within state government;

14 ~~(k)~~(L) incentives to be used to contain costs, PROVIDE

15 MARKET CONTROL, and direct resources;

16 ~~(l)~~(M) administrative efficiencies;

17 ~~(m)~~(N) the appropriate use of midlevel practitioners,

18 such as physician's assistants and nurse practitioners;

19 ~~(n)~~(O) mechanisms for reducing the cost of prescription

20 drugs, both as part of and as separate from the uniform

21 benefit plan;

22 (P) INCENTIVES FOR MARKET CONTROL;

23 ~~(o)~~(Q) integration, to the extent possible under

24 federal and state law, of benefits provided under the health

25 care system with benefits provided by the Indian health

1 service and the United States department of veteran affairs

2 and benefits provided by the medicare and medicaid programs;

3 and

4 ~~(p)~~(R) an actuarially sound estimate of the costs of

5 implementing the plan through the year 2005.

6 (3) NOTHING IN [SECTIONS 7 THROUGH 9 AND 11] OR THIS

7 SECTION MAY BE INTERPRETED TO PREVENT MONTANA RESIDENTS FROM

8 SEEKING HEALTH CARE SERVICES NOT PROVIDED IN EITHER OR BOTH

9 STATEWIDE PLANS.

10 NEW SECTION. Section 7. Cost containment. (1) The

11 statewide plans must contain a cost containment component,

12 INCLUDING ANNUAL COST CONTAINMENT TARGETS. Except as

13 otherwise provided in this section, each statewide plan must

14 establish a-target TARGETS for cost containment so that by

15 1999, the annual average percentage increase in statewide

16 health care costs does not exceed the average annual

17 percentage increase in the gross domestic product, as

18 determined by the U.S. department of commerce, for the 5

19 preceding years.

20 (2) The authority shall adopt processes and criteria

21 for responding to exceptional and unforeseen circumstances

22 that affect the health care system and the target TARGETS

23 required in subsection (1), including such factors as

24 population increases or decreases, demographic changes,

25 costs beyond the control of health care providers, and other

factors that the authority considers significant.

(3) The authority shall, AT A MINIMUM, include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis AND AN INDIVIDUAL'S CHOICE OF SERVICES.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the same rate for the same health care services and items and that reimbursement for services is based predominantly upon the health care service provided rather than upon the discipline of the health care provider.

(d) a method of monitoring compliance with the target TARGETS required in subsection (1);

(e) expenditure targets for health care providers and facilities;

(f) disincentives for exceeding the targets established pursuant to subsection (3)(e), including reduction of reimbursement levels in subsequent years;

(g) reimbursement of health care providers and health care facilities that is based upon negotiated annual budgets

or fees for services; and

(h) a plan by the authority, health care providers, health insurers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

NEW SECTION. **Section 8. Health care resource management plan.** (1) Each statewide plan must contain a health care resource management plan that takes into account the provisions of [section 7]. The management plan must provide for the distribution of health care resources within the regions established pursuant to [section 17] and within the state as a whole, consistent with the principles provided in subsection (2).

(2) The management plan must include:

(a) a statement of principles used in the allocation of resources and in establishing priorities for health services;

(b) identification of the current supply and distribution of:

(i) hospital, nursing home, and other inpatient services;

(ii) home health and mental health services;

(iii) treatment services for alcohol and drug abuse;

(iv) emergency care;

(v) ambulatory care services, including primary care

1 resources;

2 (vi) nutrition benefits, prenatal benefits, and

3 maternity care;

4 (vii) human resources;

5 (VIII) HEALTH SCIENCES LIBRARY RESOURCES AND SERVICES;

6 ~~(viii)~~ (IX) major medical equipment; and

7 ~~(ix)~~ (X) health screening and early intervention

8 services;

9 (c) a determination of the appropriate supply and

10 distribution of the resources and services identified in

11 subsection (2)(b) and of the mechanisms that will encourage

12 the appropriate integration of these services on a local or

13 regional basis. To arrive at a determination, the authority

14 shall consider the following factors:

15 (i) the needs of the statewide population, with special

16 consideration given to the development of health care

17 services in underserved areas of the state;

18 (ii) the needs of particular geographic areas of the

19 state;

20 (iii) the use of Montana facilities by out-of-state

21 residents;

22 (iv) the use of out-of-state facilities by Montana

23 residents;

24 (v) the needs of populations with special health care

25 needs;

1 (vi) the desirability of providing high-quality services

2 in an economical and efficient manner, including the

3 appropriate use of midlevel practitioners; and

4 (vii) the cost impact of these resource requirements on

5 health care expenditures;

6 (d) a component that addresses health promotion and

7 disease prevention and that is prepared by the department of

8 health and environmental sciences in a format established by

9 the authority;

10 (e) incentives to improve access to and use of

11 preventive care; primary care services, including mental

12 health services; and community-based care;

13 (f) incentives for healthy lifestyles;

14 (g) incentives to improve access to health care in

15 underserved areas, including:

16 (i) a system by which the authority may identify

17 persons with an interest in becoming health care

18 professionals and provide or assist in providing health care

19 education for those persons; and

20 (ii) tax credits and other financial incentives to

21 attract and retain health care professionals in underserved

22 areas; and

23 (h) a component that addresses integration of the plan,

24 to the extent allowed by state and federal law, with

25 services provided by the Indian health service and by the

1 United States department of veterans affairs and by the
2 medicare and medicaid programs.

3 (3) In adopting the management plan, the authority
4 shall consider the regional health resource plans
5 recommended by regional panels.

6 (4) The management plan must be revised annually in a
7 manner determined by the authority.

8 (5) Prior to adoption of the management plan, the
9 authority shall hold one or more public hearings for the
10 purpose of receiving oral and written comment on a draft
11 plan. After hearings have been concluded, the authority
12 shall adopt the management plan, taking comments into
13 consideration.

14 NEW SECTION. Section 9. Health care billing
15 simplification. (1) Each statewide plan must contain a
16 component providing for simplification and reduction of the
17 costs associated with health care billing. In designing this
18 component, the authority may consider:

19 (a) conversion from paper health care claims to
20 standardized electronic billing; and

21 (b) creating a claims clearinghouse, consisting of a
22 state agency or private entity, to receive claims from all
23 health care providers for compiling, editing, and submitting
24 the claims to payors.

25 (2) The health care billing component must include a

1 method to educate and assist health care providers and
2 payors who will use any health care billing simplification
3 system recommended by the authority.

4 (3) The billing component must provide a schedule for a
5 phasein of any health care billing simplification system
6 recommended by the authority. The schedule must relieve
7 health care providers, payors, and consumers of undue
8 burdens in using the system.

9 NEW SECTION. Section 10. Uniform claim forms and
10 procedures. (1) ~~By January 17, 1994, the~~ THE commissioner of
11 insurance, after consultation with the authority, may adopt
12 by rule uniform health insurance claim forms and uniform
13 standards and procedures for the use of the forms and
14 processing of claims, including the submission of claims by
15 means of an electronic claims processing system.

16 (2) The commissioner may contract with a private or
17 public entity to administer and operate an electronic claims
18 processing system. If the commissioner elects to contract
19 for administration and operation of the system, the
20 commissioner shall award a contract according to Title 18,
21 chapter 4.

22 NEW SECTION. Section 11. Other matters to be included
23 in statewide plans. (1) The statewide plans recommended by
24 the authority must include:

25 (a) stable financing methods, including sharing of the

costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of a system for reducing the use of defensive medicine by adopting practice protocols that would give providers guidelines to follow for specific procedures;

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

(iii) propose any changes, including legislation, that it considers necessary, including measures for compensating victims of tortious injuries.

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority ~~shall~~ MAY include in its plans legislation IN ADDITION TO [SECTIONS 37 THROUGH 44] that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

NEW SECTION. Section 12. Hearings AVAILABILITY OF PLANS -- HEARINGS on statewide plans. (1) THE AUTHORITY SHALL MAKE COPIES OF THE DRAFT STATEWIDE PLANS WIDELY AVAILABLE AT PUBLIC EXPENSE TO INTERESTED PERSONS AND GROUPS.

(2) The authority shall seek public comment on the development of each statewide plan required under [section

5]. In seeking public comment on the development of the authority's recommendations for each plan, the authority shall provide extensive, multimedia notice to the public and hold at least one public hearing in each of the health care planning regions established by [section 17]. The hearings must take place before the authority's report is submitted to the legislature. The authority shall consult with health care providers in the development of its recommendations for each statewide plan.

(3) THE AUTHORITY SHALL CONSIDER ORAL AND WRITTEN PUBLIC COMMENTS ON THE STATEWIDE PLANS BEFORE RECOMMENDING THEM TO THE LEGISLATURE.

NEW SECTION. Section 13. State purchasing pool -- reports required. (1) On or before December 15, 1994, and December 15, 1996, the authority shall report to the legislature on establishment of a state purchasing pool, including the number and types of groups and group members participating in the pool, the costs of administering the pool, the savings attributable to participating groups from the operation of the pool, and any changes in legislation considered necessary by the authority.

(2) On or before December 15, 1996, the authority shall report to the legislature its recommendations concerning the feasibility and merits of authorizing the authority to act as an insurer in pooling risks and providing benefits,

including a common benefits plan, to participants of the purchasing pool.

NEW SECTION. Section 14. Study of prescription drug cost and distribution. The authority shall conduct a study of the cost and distribution of prescription drugs in this state. The study must consider the feasibility of various methods of reducing the cost of purchasing and distributing prescription drugs to Montana residents. The study must include the feasibility of establishing a prescription drug purchasing pool for distribution of drugs through pharmacists in this state. The results of the study, including the authority's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1996. If the authority determines that feasible methods are available without need for legislation or appropriations, the authority shall implement that part or those parts of its recommendations.

NEW SECTION. Section 15. Long-term care study and recommendations. (1) The authority shall conduct a study of the long-term care needs of state residents and report to the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on

1 its report in each region established under [section 17].
 2 The authority shall present its report to the legislature on
 3 or before January 1, 1997.

4 (2) This section does not preclude the authority from
 5 recommending cost-sharing arrangements for long-term care
 6 services or from recommending that the services be phased in
 7 over time. The authority's recommendations must support and
 8 may not supplant informal care giving by family and friends
 9 and must include cost containment recommendations for any
 10 long-term care service suggested for inclusion.

11 (3) The authority's report must estimate costs
 12 associated with each of the long-term care services
 13 recommended and may suggest independent financing mechanisms
 14 for those services. The report must also set forth the
 15 projected cost to Montana and its citizens over the next 20
 16 years if there is no change in the present accessibility,
 17 affordability, or financing of long-term care services in
 18 this state.

19 (4) The authority shall consult with the department of
 20 social and rehabilitation services in developing its
 21 recommendations under this section.

22 **NEW SECTION. Section 16. Study of certificate of need**
 23 **process.** (1) The authority shall conduct a study of the
 24 certificate of need process established under Title 50,
 25 chapter 5, part 3. The study must determine whether changes

1 in the certificate of need process are necessary or
 2 desirable in light of the authority's recommendation for a
 3 single payor health care system required by [section 5]. The
 4 study must include consideration of the role, effect, and
 5 desirability of:

6 (a) maintaining the exemptions from the certificate of
 7 need process for HOSPITALS AND FOR offices of private
 8 physicians, dentists, and other physical and mental health
 9 care professionals; and

10 (b) maintaining the dollar thresholds for health care
 11 services, equipment, and buildings and for construction of
 12 health care facilities.

13 (2) The results of the study, including any
 14 recommendations for legislation and changes in an agency's
 15 policies or rules, must be reported to the legislature no
 16 later than December 1, 1994.

17 **NEW SECTION. Section 17. Health care planning regions**
 18 **and regional planning boards created -- selection --**
 19 **membership.** (1) There are five health care planning regions.
 20 Subject to subsection (2), the regions must consist of the
 21 following counties:

22 (a) region I: Sheridan, Daniels, Valley, Phillips,
 23 Roosevelt, Richland, McCone, Garfield, Dawson, Prairie,
 24 Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and
 25 Carter;

(b) region II: Blaine, Hill, Liberty, Toole, Glacier, Pondera, Teton, Chouteau, and Cascade;

(c) region III: Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

(d) region IV: Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead;

(e) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

(2) (a) A county may, by written request of the board of county commissioners, petition the authority at any time to be removed from a health care planning region and added to another region.

(b) The authority shall grant or deny the petition after a public hearing. The authority shall give notice as the authority determines appropriate. The authority shall grant the petition if it appears by a preponderance of the evidence that the petitioning county's health care interests are more strongly associated with the region that the county seeks to join than with the region in which the county is located. If the authority grants the petition, the county is considered for all purposes to be part of the health care planning region as approved by the authority.

(3) Within each region, the authority shall establish

by rule a regional health care planning board. Each board must include one member from each county within the region. The members on each board shall represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care. Each regional board should attempt to achieve gender balance.

(4) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select the members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(5) Regional board members serve 4-year terms, except that of the board members initially selected, at least three members serve for 2 years, at least three members serve for 3 years, and at least three members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve a 4-year term. Board members must be compensated and reimbursed in accordance with 2-15-124.

NEW SECTION. Section 18. Powers and duties of boards.

(1) A board shall:

(a) meet at the time and place designated by the

1 presiding officer, but not less than quarterly;

2 (b) submit an annual budget and grant application to
3 the authority at the time and in the manner directed by the
4 authority;

5 (c) adopt procedures governing its meetings and other
6 aspects of its day-to-day operations as the board determines
7 necessary;

8 (d) develop regional health resource plans in the
9 format determined by the authority that must address the
10 health care needs of the region and address the development
11 of health care services in underserved areas of the region
12 and other matters;

13 (e) revise the regional plan annually;

14 (f) hold at least one public hearing on the regional
15 plan within the region at the time and in the manner
16 determined by the regional board;

17 (g) transmit the regional plan to the authority at the
18 time determined by the authority;

19 (h) apply to the authority for grant funds for
20 operation of the regional board and account, in the manner
21 specified by the authority, for grant funds provided by the
22 authority; and

23 (i) seek from local PUBLIC AND PRIVATE sources money to
24 supplement grant funds provided by the authority.

25 (2) Regional boards may:

1 (a) recommend that the authority sanction voluntary
2 agreements between health care providers and between health
3 care consumers in the region that will improve the quality
4 of, access to, or affordability of health care but that
5 might constitute a violation of antitrust laws if undertaken
6 without government direction;

7 (b) make recommendations to the authority regarding
8 major capital expenditures or the introduction of expensive
9 new technologies and medical practices that are being
10 proposed or considered by health care providers;

11 (c) undertake voluntary activities to educate
12 consumers, providers, and purchasers and promote voluntary,
13 cooperative community cost containment, access, or quality
14 of care projects; and

15 (d) make recommendations to the department of health
16 and environmental sciences or to the authority, or both,
17 regarding ways of improving affordability, accessibility,
18 and quality of health care in the region and throughout the
19 state.

20 (3) Each regional board may review and advise the
21 authority on regional technical matters relating to the
22 statewide plans required by [section 5], the common benefits
23 package, procedures for developing and applying practice
24 guidelines for use in the statewide plans, provider and
25 facility contracts with the state, utilization review

1 recommendations, expenditure targets, and uniform health
2 care benefits and the impact of the benefits upon the
3 provision of quality health care within the region.

4 NEW SECTION. Section 19. Health care data base --
5 information submitted -- enforcement. (1) The authority
6 shall develop and maintain a unified health care data base
7 that enables the authority, on a statewide basis, to:

8 (a) determine the distribution and capacity of health
9 care resources, including health care facilities, providers,
10 and health care services;

11 (b) identify health care needs and direct statewide and
12 regional health care policy to ensure high-quality and
13 cost-effective health care;

14 (c) conduct evaluations of health care procedures and
15 health care protocols;

16 (d) compare costs of commonly performed health care
17 procedures between providers and health care facilities
18 within a region and make the data readily available to the
19 public; and

20 (e) compare costs of various health care procedures in
21 one location of providers and health care facilities with
22 the costs of the same procedures in other locations of
23 providers and health care facilities.

24 (2) The authority shall by rule require health care
25 providers, health insurers, health care facilities, private

1 entities, and entities of state and local governments to
2 file with the authority the reports, data, schedules,
3 statistics, and other information determined by the
4 authority to be necessary to fulfill the purposes of the
5 data base provided in subsection (1). Material to be filed
6 with the authority may include health insurance claims and
7 enrollment information used by health insurers.

8 (3) The authority may issue subpoenas for the
9 production of information required under this section and
10 may issue subpoenas for and administer oaths to any person.
11 Noncompliance with a subpoena issued by the authority is,
12 upon application by the authority, punishable by a district
13 court as contempt pursuant to Title 3, chapter 1, part 5.

14 (4) The data base must:

15 (a) use unique patient and provider identifiers and a
16 uniform coding system identifying health care services; and

17 (b) reflect all health care utilization, costs, and
18 resources in the state and the health care utilization and
19 costs of services provided to Montana residents in another
20 state.

21 (5) Information in the data base required by law to be
22 kept confidential must be maintained in a manner that does
23 not disclose the identity of the person to whom the
24 information applies. INFORMATION IN THE DATA BASE NOT
25 REQUIRED BY LAW TO BE KEPT CONFIDENTIAL MUST BE MADE

AVAILABLE BY THE AUTHORITY UPON REQUEST OF ANY PERSON.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

NEW SECTION. Section 20. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

(b) The authority may use plans filed under this section in the development of a unified health care budget.

(2) The plans required by this section must be developed in accordance with standards and procedures established by the authority.

(3) The provisions of this section do not apply to dental insurance.

Section 21. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is hereby--established--as the sole-and-official state agency to administer the state program for comprehensive health planning and ~~is-hereby-authorized-to~~ shall prepare a

plan for comprehensive state health planning. The ~~department authority is-authorized-to~~ may confer and cooperate with any and--all other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The ~~department~~ authority, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer any-and-all funds which-are now-available-or-which-may-be donated, granted, bequeathed, or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

NEW SECTION. Section 22. Short title. [Sections 22 through 36] may be cited as the "Small Employer Health Insurance Availability Act".

NEW SECTION. Section 23. Purpose. (1) [Sections 22 through 36] must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to

1 purchasers;

2 (d) to establish rules regarding renewability of
3 coverage;

4 (e) to establish limitations on the use of preexisting
5 condition exclusions;

6 (f) to provide for the development of basic and
7 standard health benefit plans to be offered to all small
8 employers;

9 (g) to provide for the establishment of a reinsurance
10 program; and

11 (h) to improve the overall fairness and efficiency of
12 the small employer health insurance market.

13 (2) [Sections 22 through 36] are not intended to
14 provide a comprehensive solution to the problem of
15 affordability of health care or health insurance.

16 NEW SECTION. **Section 24. Definitions.** As used in
17 [sections 22 through 36], the following definitions apply:

18 (1) "Actuarial certification" means a written statement
19 by a member of the American academy of actuaries or other
20 individual acceptable to the commissioner that a small
21 employer carrier is in compliance with the provisions of
22 [section 27], based upon the person's examination, including
23 a review of the appropriate records and of the actuarial
24 assumptions and methods used by the small employer carrier
25 in establishing premium rates for applicable health benefit

1 plans.

2 (2) "Affiliate" or "affiliated" means any entity or
3 person who directly or indirectly, through one or more
4 intermediaries, controls, is controlled by, or is under
5 common control with a specified entity or person.

6 (3) "ASSESSABLE CARRIER" MEANS ALL INDIVIDUAL CARRIERS
7 OF DISABILITY INSURANCE AND ALL CARRIERS OF GROUP DISABILITY
8 INSURANCE, THE STATE GROUP BENEFITS PLAN PROVIDED FOR IN
9 TITLE 2, CHAPTER 18, PART 8, THE MONTANA UNIVERSITY SYSTEM
10 HEALTH PLAN, AND ANY SELF-FUNDED DISABILITY INSURANCE PLAN
11 PROVIDED BY A POLITICAL SUBDIVISION OF THE STATE.

12 (4) "Base premium rate" means, for each class of
13 business as to a rating period, the lowest premium rate
14 charged or that could have been charged under the rating
15 system for that class of business by the small employer
16 carrier to small employers with similar case characteristics
17 for health benefit plans with the same or similar coverage.

18 (5) "Basic health benefit plan" means a lower cost
19 health benefit plan developed pursuant to [section 31].

20 (6) "Board" means the board of directors of the
21 program established pursuant to [section 30].

22 (7) "Carrier" means any person who provides a health
23 benefit plan in this state subject to state insurance
24 regulation. The term includes but is not limited to an
25 insurance company, a fraternal benefit society, a health

1 service corporation, a health maintenance organization, and,
 2 to the extent permitted by the Employee Retirement Income
 3 Security Act of 1974, a multiple-employer welfare
 4 arrangement. For purposes of [sections 22 through 36],
 5 companies that are affiliated companies or that are eligible
 6 to file a consolidated tax return must be treated as one
 7 carrier, except that the following may be considered as
 8 separate carriers:

9 (a) an insurance company or health service corporation
 10 that is an affiliate of a health maintenance organization
 11 located in this state;

12 (b) a health maintenance organization located in this
 13 state that is an affiliate of an insurance company or health
 14 service corporation; or

15 (c) a health maintenance organization that operates
 16 only one health maintenance organization in an established
 17 geographic service area of this state.

18 ~~(7)~~(8) "Case characteristics" means demographic or
 19 other objective characteristics of a small employer that are
 20 considered by the small employer carrier in the
 21 determination of premium rates for the small employer,
 22 provided that claims experience, health status, and duration
 23 of coverage are not case characteristics for purposes of
 24 [sections 22 through 36].

25 ~~(8)~~(9) "Class of business" means all or a separate

1 grouping of small employers established pursuant to [section
 2 26].

3 ~~(9)~~(10) "Committee" means the health benefit plan
 4 committee created pursuant to [section 31].

5 ~~(10)~~(11) "Dependent" means:

6 (a) a spouse or an unmarried child under 19 years of
 7 age;

8 (b) an unmarried child, under 23 years of age, who is a
 9 full-time student and who is financially dependent on the
 10 insured;

11 (c) a child of any age who is disabled and dependent
 12 upon the parent as provided in 33-22-506 and 33-30-1003; or

13 (d) any other individual defined to be a dependent in
 14 the health benefit plan covering the employee.

15 ~~(11)~~(12) "Eligible employee" means an employee who works
 16 on a full-time basis and who has a normal workweek of 30
 17 hours or more. The term includes a sole proprietor, a
 18 partner of a partnership, and an independent contractor if
 19 the sole proprietor, partner, or independent contractor is
 20 included as an employee under a health benefit plan of a
 21 small employer. The term does not include an employee who
 22 works on a part-time, temporary, or substitute basis.

23 ~~(12)~~(13) "Established geographic service area" means a
 24 geographic area, as approved by the commissioner and based
 25 on the carrier's certificate of authority to transact

insurance in this state, within which the carrier is authorized to provide coverage.

{13}(14) "Health benefit plan" means any hospital or medical policy or certificate PROVIDING FOR PHYSICAL AND MENTAL HEALTH CARE issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

{14}(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

{15}(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However,

an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

{16}(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health

benefit plans with the same or similar coverage.

~~(17)~~(18) "Plan of operation" means the operation of the program established pursuant to [section 30].

~~(18)~~(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~(19)~~(20) "Program" means the Montana small employer health reinsurance program created by [section 30].

~~(20)~~(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

~~(21)~~(22) "Rating period" means the calendar period for

which premium rates established by a small employer carrier are assumed to be in effect.

~~(22)~~(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to [section 30].

~~(23)~~(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

~~(24)~~(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation OR THAT ARE MEMBERS OF AN ASSOCIATION THAT HAS BEEN IN EXISTENCE FOR 1 YEAR PRIOR TO [THE EFFECTIVE DATE OF SECTIONS 22 THROUGH 36] AND THAT PROVIDES A HEALTH BENEFIT PLAN TO EMPLOYEES OF ITS MEMBERS

AS A GROUP are considered one employer.

~~(25)~~(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

~~(26)~~(27) "Standard health benefit plan" means a health benefit plan developed pursuant to [section 31].

NEW SECTION. Section 25. Applicability and scope. [Sections 22 through 35] apply to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

NEW SECTION. Section 26. Establishment of classes of business. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative

costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner may SHALL adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. Section 27. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under [sections 22 through 36] are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate; or

(ii) if the Montana health care authority established by [section 3] certifies to the commissioner that the cost containment goal set forth in [section 7] is met on or before January 1, 1999, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage may not vary from the index by more than 20% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; ~~In; IN~~ the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the

small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

~~(e) Premium rates for health benefit plans must comply with the requirements of this section, notwithstanding any assessments paid or payable by small employer carriers pursuant to section 30.~~

1 {f}(E) If a small employer carrier uses industry as a
2 case characteristic in establishing premium rates, the rate
3 factor associated with any industry classification may not
4 vary from the average of the rate factors associated with
5 all industry classifications by more than 15% of that
6 coverage.

7 {g}(F) In the case of health benefit plans delivered or
8 issued for delivery prior to January 1, 1994, a premium rate
9 for a rating period may exceed the ranges set forth in
10 subsections (1)(a) and (1)(b) until January 1, 1997. In that
11 case, the percentage increase in the premium rate charged to
12 a small employer for a new rating period may not exceed the
13 sum of the following:

14 (i) the percentage change in the new business premium
15 rate measured from the first day of the prior rating period
16 to the first day of the new rating period; ~~in~~ IN the case
17 of a health benefit plan into which the small employer
18 carrier is no longer enrolling new small employers, the
19 small employer carrier shall use the percentage change in
20 the base premium rate, provided that the change does not
21 exceed, on a percentage basis, the change in the new
22 business premium rate for the most similar health benefit
23 plan into which the small employer carrier is actively
24 enrolling new small employers; AND

25 (ii) any adjustment because of a change in coverage or a

1 change in the case characteristics of the small employer, as
2 determined from the small employer carrier's rate manual for
3 the class of business.

4 {h}(G) A small employer carrier shall:

5 (i) apply rating factors, including case
6 characteristics, consistently with respect to all small
7 employers in a class of business. Rating factors must
8 produce premiums for identical groups that differ only by
9 the amounts attributable to plan design and that do not
10 reflect differences because of the nature of the groups.

11 (ii) treat all health benefit plans issued or renewed in
12 the same calendar month as having the same rating period.

13 {i}(H) For the purposes of this subsection (1), a
14 health benefit plan that includes a restricted network
15 provision may not be considered similar coverage to a health
16 benefit plan that does not include a restricted network
17 provision.

18 {j} ~~The small employer carrier may not use case~~
19 ~~characteristics, other than age, without prior approval of~~
20 ~~the commissioner.~~

21 {k}(I) The commissioner may SHALL adopt rules to
22 implement the provisions of this section and to ensure that
23 rating practices used by small employer carriers are
24 consistent with the purposes of [sections 22 through 36],
25 including rules that ensure that differences in rates

1 charged for health benefit plans by small employer carriers
2 are reasonable and reflect objective differences in plan
3 design, not including differences because of the nature of
4 the groups.

5 (2) A small employer carrier may not transfer a small
6 employer involuntarily into or out of a class of business. A
7 small employer carrier may not offer to transfer a small
8 employer into or out of a class of business unless the offer
9 is made to transfer all small employers in the class of
10 business without regard to case characteristics, claims
11 experience, health status, or duration of coverage since the
12 insurance was issued.

13 (3) The commissioner may suspend for a specified period
14 the application of subsection (1)(a) for the premium rates
15 applicable to one or more small employers included within a
16 class of business of a small employer carrier for one or
17 more rating periods upon a filing by the small employer
18 carrier and a finding by the commissioner either that the
19 suspension is reasonable in light of the financial condition
20 of the small employer carrier or that the suspension would
21 enhance the fairness and efficiency of the small employer
22 health insurance market.

23 (4) In connection with the offering for sale of any
24 health benefit plan to a small employer, a small employer
25 carrier shall make a reasonable disclosure, as part of its

1 solicitation and sales materials, of each of the following:

2 (a) the extent to which premium rates for a specified
3 small employer are established or adjusted based upon the
4 actual or expected variation in claims costs or upon the
5 actual or expected variation in health status of the
6 employees of small employers and the employees' dependents;

7 (b) the provisions of the health benefit plan
8 concerning the small employer carrier's right to change
9 premium rates and the factors, other than claims experience,
10 that affect changes in premium rates;

11 (c) the provisions relating to renewability of policies
12 and contracts; and

13 (d) the provisions relating to any preexisting
14 condition.

15 (5) (a) Each small employer carrier shall maintain at
16 its principal place of business a complete and detailed
17 description of its rating practices and renewal underwriting
18 practices, including information and documentation that
19 demonstrate that its rating methods and practices are based
20 upon commonly accepted actuarial assumptions and are in
21 accordance with sound actuarial principles.

22 (b) Each small employer carrier shall file with the
23 commissioner annually, on or before March 15, an actuarial
24 certification certifying that the carrier is in compliance
25 with [sections 22 through 36] and that the rating methods of

the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of [sections 22 through 36] and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

NEW SECTION. Section 28. Renewability of coverage. (1)

A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.

(g) the commissioner finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations.

(2) If the commissioner makes a finding under

1 subsection (1)(g), the commissioner shall assist affected
2 small employers in finding replacement coverage.

3 (3) A small employer carrier that elects not to renew a
4 health benefit plan under subsection (1)(f) is prohibited
5 from writing new business in the small employer market in
6 this state for a period of 5 years from the date of notice
7 to the commissioner.

8 (4) In the case of a small employer carrier doing
9 business in one established geographic service area of the
10 state, the rules set forth in this section apply only to the
11 carrier's operations in that service area.

12 NEW SECTION. Section 29. Availability of coverage --
13 required plans. (1) (a) As a condition of transacting
14 business in this state with small employers, each small
15 employer carrier shall offer to small employers at least two
16 health benefit plans. One plan must be a basic health
17 benefit plan, and one plan must be a standard health benefit
18 plan.

19 (b) (i) A small employer carrier shall issue a basic
20 health benefit plan or a standard health benefit plan to any
21 eligible small employer that applies for either plan and
22 agrees to make the required premium payments and to satisfy
23 the other reasonable provisions of the health benefit plan
24 not inconsistent with [sections 22 through 36].

25 (ii) In the case of a small employer carrier that

1 establishes more than one class of business pursuant to
2 [section 26], the small employer carrier shall maintain and
3 offer to eligible small employers at least one basic health
4 benefit plan and at least one standard health benefit plan
5 in each established class of business. A small employer
6 carrier may apply reasonable criteria in determining whether
7 to accept a small employer into a class of business,
8 provided that:

9 (A) the criteria are not intended to discourage or
10 prevent acceptance of small employers applying for a basic
11 or standard health benefit plan;

12 (B) the criteria are not related to the health status
13 or claims experience of the small employers' employees;

14 (C) the criteria are applied consistently to all small
15 employers that apply for coverage in that class of business;
16 and

17 (D) the small employer carrier provides for the
18 acceptance of all eligible small employers into one or more
19 classes of business.

20 (iii) The provisions of subsection (1)(b)(ii) may not be
21 applied to a class of business into which the small employer
22 carrier is no longer enrolling new small businesses.

23 (c) The provisions of this section are effective 180
24 days after the commissioner's approval of the basic health
25 benefit plan and the standard health benefit plan developed

pursuant to [section 31], provided that if the program created pursuant to [section 30] is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of [sections 22 through 36].

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-216, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or

limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application

of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

NEW SECTION. Section 30. Small employer carrier reinsurance program -- board membership -- plan of operation -- criteria -- exemption from taxation. (1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2) (a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b) (i) In selecting the members of the board, the

commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

(ii) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

(iii) A vacancy on the board must be filled by the

commissioner. The commissioner may remove a board member for cause.

(3) Within [60 days of the effective date of this section] AND ON OR BEFORE MARCH 1 OF EACH YEAR AFTER THAT DATE, each ~~small-employer~~ ASSESSABLE carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued to ~~small-employers~~ in this state in the previous calendar year.

(4) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(5) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall

1 amend or rescind any temporary plan adopted under this
2 subsection at the time a plan of operation is submitted by
3 the board and approved by the commissioner.

4 (6) The plan of operation must:

5 (a) establish procedures for the handling and
6 accounting of program assets and money and for an annual
7 fiscal reporting to the commissioner;

8 (b) establish procedures for selecting an administering
9 carrier and setting forth the powers and duties of the
10 administering carrier;

11 (c) establish procedures for reinsuring risks in
12 accordance with the provisions of this section;

13 (d) establish procedures for collecting assessments
14 from reinsuring ASSESSABLE carriers to fund claims and
15 administrative-expenses incurred or-estimated-to-be-incurred
16 by the program; and

17 (E) ESTABLISH PROCEDURES FOR ALLOCATING A PORTION OF
18 PREMIUMS COLLECTED FROM REINSURING CARRIERS TO FUND
19 ADMINISTRATIVE EXPENSES INCURRED OR TO BE INCURRED BY THE
20 PROGRAM; AND

21 ~~(e)~~(F) provide for any additional matters necessary for
22 the implementation and administration of the program.

23 (7) The program ~~must--have~~ HAS the general powers and
24 authority granted under the laws of this state to insurance
25 companies and health maintenance organizations licensed to

1 transact business, except the power to issue health benefit
2 plans directly to either groups or individuals. In addition,
3 the program ~~must-have-the-specific-authority-to~~ MAY:

4 (a) enter into contracts as are necessary or proper to
5 carry out the provisions and purposes of [sections 22
6 through 36], including the authority, with the approval of
7 the commissioner, to enter into contracts with similar
8 programs of other states for the joint performance of common
9 functions or with persons or other organizations for the
10 performance of administrative functions;

11 (b) sue or be sued, including taking any legal actions
12 necessary or proper to recover any ~~assessments~~ PREMIUMS and
13 penalties for, on behalf of, or against the program or any
14 reinsuring carriers;

15 (c) take any legal action necessary to avoid the
16 payment of improper claims against the program;

17 (d) define the health benefit plans for which
18 reinsurance will be provided and to issue reinsurance
19 policies in accordance with the requirements of [sections 22
20 through 36];

21 (e) establish ~~rules~~, conditions, and procedures for
22 reinsuring risks under the program;

23 (f) establish actuarial functions as appropriate for
24 the operation of the program;

25 (g) appoint appropriate legal, actuarial, and other

committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program; and

(H) TO THE EXTENT PERMITTED BY FEDERAL LAW AND IN ACCORDANCE WITH SUBSECTION (11)(C), MAKE ANNUAL FISCAL YEAREND ASSESSMENTS AGAINST ASSESSABLE CARRIERS AND MAKE INTERIM ASSESSMENTS TO FUND CLAIMS INCURRED BY THE PROGRAM; AND

~~(h)~~(I) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection (8):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following

the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance

1 with the program for one or more of the reinsured employees
2 or dependents of a small employer on any anniversary of the
3 health benefit plan.

4 (f) A small employer group business HEALTH BENEFIT PLAN
5 in effect before January 1, 1994, may not be reinsured by
6 the program until January 1, 1997, and then only if the
7 board determines that sufficient funding sources are
8 available.

9 (g) A reinsuring carrier shall apply all managed care
10 and claims-handling techniques, including utilization
11 review, individual case management, preferred provider
12 provisions, and other managed care provisions or methods of
13 operation consistently with respect to reinsured and
14 nonreinsured business.

15 (9) (a) As part of the plan of operation, the board
16 shall establish a methodology for determining premium rates
17 to be charged by the program for reinsuring small employers
18 and individuals pursuant to this section. The methodology
19 must include a system for classification of small employers
20 that reflects the types of case characteristics commonly
21 used by small employer carriers in the state. The
22 methodology must provide for the development of base
23 reinsurance premium rates that must be multiplied by the
24 factors set forth in subsection (9)(b) to determine the
25 premium rates for the program. The base reinsurance premium

1 rates must be established by the board, subject to the
2 approval of the commissioner, and must be set at levels that
3 reasonably approximate gross premiums charged to small
4 employers by small employer carriers for health benefit
5 plans with benefits similar to the standard health benefit
6 plan, adjusted to reflect retention levels required under
7 [sections 22 through 36].

8 (b) Premiums for the program are as follows:

9 (i) An entire small employer group may be reinsured for
10 a rate that is one and one-half times the base reinsurance
11 premium rate for the group established pursuant to this
12 subsection (9).

13 (ii) An eligible employee or dependent may be reinsured
14 for a rate that is five times the base reinsurance premium
15 rate for the individual established pursuant to this
16 subsection (9).

17 (c) The board periodically shall review the methodology
18 established under subsection (9)(a), including the system of
19 classification and any rating factors, to ensure that it
20 reasonably reflects the claims experience of the program.
21 The board may propose changes to the methodology that are
22 subject to the approval of the commissioner.

23 (d) The board may consider adjustments to the premium
24 rates charged by the program to reflect the use of effective
25 cost containment and managed care arrangements.

(10) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in [section 27].

(11) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) ~~A net loss for the year must be reimbursed by the commissioner from funds specifically appropriated for that purpose.~~ TO THE EXTENT PERMITTED BY FEDERAL LAW, EACH ASSESSABLE CARRIER SHALL SHARE IN ANY NET LOSS OF THE PROGRAM FOR THE YEAR IN AN AMOUNT EQUAL TO THE RATIO OF THE TOTAL PREMIUMS EARNED IN THE PREVIOUS CALENDAR YEAR FROM HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY BY EACH ASSESSABLE CARRIER DIVIDED BY THE TOTAL PREMIUMS EARNED IN THE PREVIOUS CALENDAR YEAR FROM HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY BY ALL ASSESSABLE CARRIERS IN THE STATE.

(C) THE BOARD SHALL MAKE AN ANNUAL DETERMINATION IN ACCORDANCE WITH THIS SECTION OF EACH ASSESSABLE CARRIER'S LIABILITY FOR ITS SHARE OF THE NET LOSS OF THE PROGRAM AND,

EXCEPT AS OTHERWISE PROVIDED BY THIS SECTION, MAKE AN ANNUAL FISCAL YEAREND ASSESSMENT AGAINST EACH ASSESSABLE CARRIER TO THE EXTENT OF THAT LIABILITY. IF APPROVED BY THE COMMISSIONER, THE BOARD MAY ALSO MAKE INTERIM ASSESSMENTS AGAINST ASSESSABLE CARRIERS TO FUND CLAIMS INCURRED BY THE PROGRAM. ANY INTERIM ASSESSMENT MUST BE CREDITED AGAINST THE AMOUNT OF ANY FISCAL YEAREND ASSESSMENT DUE OR TO BE DUE FROM AN ASSESSABLE CARRIER. PAYMENT OF A FISCAL YEAREND OR INTERIM ASSESSMENT IS DUE WITHIN 30 DAYS OF RECEIPT BY THE ASSESSABLE CARRIER OF WRITTEN NOTICE OF THE ASSESSMENT. AN ASSESSABLE CARRIER THAT CEASES DOING BUSINESS WITHIN THE STATE IS LIABLE FOR ASSESSMENTS UNTIL THE END OF THE CALENDAR YEAR IN WHICH THE ASSESSABLE CARRIER CEASED DOING BUSINESS. THE BOARD MAY DETERMINE NOT TO ASSESS AN ASSESSABLE CARRIER IF THE ASSESSABLE CARRIER'S LIABILITY DETERMINED IN ACCORDANCE WITH THIS SECTION DOES NOT EXCEED \$10.

(12) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by [sections 22 through 36] may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(13) The board, as part of the plan of operation, shall

develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program is exempt from taxation.

(15) ON OR BEFORE MARCH 1 OF EACH YEAR, THE COMMISSIONER SHALL EVALUATE THE OPERATION OF THE PROGRAM AND REPORT TO THE GOVERNOR AND THE LEGISLATURE IN WRITING THE RESULTS OF THE EVALUATION. THE REPORT MUST INCLUDE AN ESTIMATE OF FUTURE COSTS OF THE PROGRAM, ASSESSMENTS NECESSARY TO PAY THOSE COSTS, THE APPROPRIATENESS OF PREMIUMS CHARGED BY THE PROGRAM, THE LEVEL OF INSURANCE RETENTION UNDER THE PROGRAM, THE COST OF COVERAGE OF SMALL EMPLOYERS, AND ANY RECOMMENDATIONS FOR CHANGE TO THE PLAN OF OPERATION.

NEW SECTION. Section 31. Health benefit plan committee
 -- recommendations. (1) The commissioner shall appoint a health benefit plan committee. The committee is composed of ~~representatives-of-carriers,-small-employers-and--employees,-~~
~~health-care-providers,-and-producers.~~ THE FOLLOWING MEMBERS:

(A) ONE HEALTH CARE PROVIDER;

(B) ONE REPRESENTATIVE OF THE HEALTH INSURANCE INDUSTRY;

(C) ONE EMPLOYEE OF A SMALL EMPLOYER;

(D) ONE MEMBER OF A LABOR UNION; AND

(E) ONE REPRESENTATIVE OF THE GENERAL PUBLIC WHO MAY NOT REPRESENT THE PERSONS OR GROUPS LISTED IN SUBSECTIONS (1)(A) THROUGH (1)(D).

(2) The committee shall, AFTER HOLDING A PUBLIC HEARING, recommend the form and level of coverages to be made by small employer carriers pursuant to [section 29].

(3) (a) The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan that contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(b) The plans recommended by the committee must include cost containment features, such as:

(i) utilization review of health care services, including review of the medical necessity of hospital and physician services;

1 (ii) case management;
 2 (iii) selective contracting with hospitals, physicians,
 3 and other health care providers;
 4 (iv) reasonable benefit differentials applicable to
 5 providers that participate or do not participate in
 6 arrangements using restricted network provisions; and
 7 (v) other managed care provisions.
 8 (c) The committee shall submit the health benefit plans
 9 described in subsections (3)(a) and (3)(b) to the
 10 commissioner ~~for approval~~ within 180 days after the
 11 appointment of the committee. THE COMMISSIONER SHALL ADOPT
 12 AS A RULE PURSUANT TO TITLE 2, CHAPTER 4, PART 3, THE HEALTH
 13 BENEFIT PLANS REQUIRED BY [SECTION 29(1)] TO BE OFFERED IN
 14 THIS STATE.

15 NEW SECTION. Section 32. Periodic market evaluation --
 16 report. The board, in consultation with members of the
 17 committee, shall study and report at least every 3 years to
 18 the commissioner on the effectiveness of [sections 22
 19 through 36]. The report must analyze the effectiveness of
 20 [sections 22 through 36] in promoting rate stability,
 21 product availability, and coverage affordability. The report
 22 may contain recommendations for actions to improve the
 23 overall effectiveness, efficiency, and fairness of the small
 24 employer health insurance markets. The report must address
 25 whether carriers and producers are fairly and actively

1 marketing or issuing health benefit plans to small employers
 2 in fulfillment of the purposes of [sections 22 through 36].
 3 The report may contain recommendations for market conduct or
 4 other regulatory standards or action.

5 NEW SECTION. Section 33. Waiver of certain laws. A law
 6 that requires the inclusion of a specific category of
 7 licensed health care practitioner ~~does~~ PRACTITIONERS AND A
 8 LAW THAT REQUIRES THE COVERAGE OF A HEALTH CARE SERVICE OR
 9 BENEFIT DO not apply to a basic health benefit plan
 10 delivered or issued for delivery to small employers in this
 11 state pursuant to [sections 22 through 36] BUT DO APPLY TO A
 12 STANDARD HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR
 13 DELIVERY TO SMALL EMPLOYERS IN THIS STATE PURSUANT TO
 14 [SECTIONS 22 THROUGH 36].

15 NEW SECTION. Section 34. Administrative procedure. The
 16 commissioner shall adopt rules in accordance with the
 17 Montana Administrative Procedure Act to implement and
 18 administer [sections 22 through 36].

19 NEW SECTION. Section 35. Standards to ensure fair
 20 marketing. (1) Each small employer carrier shall actively
 21 market health benefit plan coverage, including the basic and
 22 standard health benefit plans, to eligible small employers
 23 in the state. If a small employer carrier denies coverage
 24 other than the basic or standard health benefit plans to a
 25 small employer on the basis of claims experience of the

small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a

producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or

1 otherwise exclude an employee from health coverage or
2 benefits provided in connection with the employee's
3 employment.

4 (7) Denial by a small employer carrier of an
5 application for coverage from a small employer must be in
6 writing and must state the reason or reasons for the denial.

7 (8) The commissioner may adopt rules setting forth
8 additional standards to provide for the fair marketing and
9 broad availability of health benefit plans to small
10 employers in this state.

11 (9) (a) A violation of this section by a small employer
12 carrier or a producer is an unfair trade practice under
13 33-18-102.

14 (b) If a small employer carrier enters into a contract,
15 agreement, or other arrangement with an administrator who
16 holds a certificate of registration pursuant to 33-17-603 to
17 provide administrative, marketing, or other services related
18 to the offering of health benefit plans to small employers
19 in this state, the administrator is subject to this section
20 as if the administrator were a small employer carrier.

21 NEW SECTION. Section 36. Restoration of terminated
22 coverage. The commissioner may promulgate rules to require
23 small employer carriers, as a condition of transacting
24 business with small employers in this state after [the
25 effective date of this section], to reissue a health benefit

1 plan to any small employer whose health benefit plan has
2 been terminated or not renewed by the carrier after [6
3 months prior to the effective date of this section]. The
4 commissioner may prescribe the terms for the reissuance of
5 coverage that the commissioner finds are reasonable and
6 necessary to provide continuity of coverage to small
7 employers.

8 NEW SECTION. SECTION 37. FINDING AND PURPOSE. THE
9 LEGISLATURE FINDS THAT THE GOALS OF CONTROLLING HEALTH CARE
10 COSTS AND IMPROVING THE QUALITY OF AND ACCESS TO HEALTH CARE
11 WILL BE SIGNIFICANTLY ENHANCED IN SOME CASES BY COOPERATIVE
12 AGREEMENTS AMONG HEALTH CARE FACILITIES. THE PURPOSE OF
13 [SECTIONS 37 THROUGH 44] IS TO PROVIDE THE STATE, THROUGH
14 THE AUTHORITY, WITH DIRECT SUPERVISION AND CONTROL OVER THE
15 IMPLEMENTATION OF COOPERATIVE AGREEMENTS AMONG HEALTH CARE
16 FACILITIES FOR WHICH CERTIFICATES OF PUBLIC ADVANTAGE ARE
17 GRANTED. IT IS THE INTENT OF THE LEGISLATURE THAT
18 SUPERVISION AND CONTROL OVER THE IMPLEMENTATION OF THESE
19 AGREEMENTS SUBSTITUTE STATE REGULATION OF FACILITIES FOR
20 COMPETITION BETWEEN FACILITIES AND THAT THIS REGULATION HAVE
21 THE EFFECT OF GRANTING THE PARTIES TO THE AGREEMENTS STATE
22 ACTION IMMUNITY FOR ACTIONS THAT MIGHT OTHERWISE BE
23 CONSIDERED TO BE IN VIOLATION OF STATE OR FEDERAL, OR BOTH,
24 ANTITRUST LAWS.

25 NEW SECTION. SECTION 38. COOPERATIVE AGREEMENTS

ALLOWED. A HEALTH CARE FACILITY MAY ENTER INTO A COOPERATIVE AGREEMENT WITH ONE OR MORE HEALTH CARE FACILITIES.

NEW SECTION. SECTION 39. CERTIFICATE OF PUBLIC ADVANTAGE -- STANDARDS FOR CERTIFICATION -- TIME FOR ACTION BY AUTHORITY. (1) PARTIES TO A COOPERATIVE AGREEMENT MAY APPLY TO THE AUTHORITY FOR A CERTIFICATE OF PUBLIC ADVANTAGE. THE APPLICATION FOR A CERTIFICATE MUST INCLUDE A COPY OF THE PROPOSED OR EXECUTED AGREEMENT, A DESCRIPTION OF THE SCOPE OF THE COOPERATION CONTEMPLATED BY THE AGREEMENT, AND THE AMOUNT, NATURE, SOURCE, AND RECIPIENT OF ANY CONSIDERATION PASSING TO ANY PERSON UNDER THE TERMS OF THE AGREEMENT.

(2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE APPLICATION FOR A CERTIFICATE BEFORE ACTING UPON THE APPLICATION. THE AUTHORITY MAY NOT ISSUE A CERTIFICATE UNLESS THE AUTHORITY FINDS THAT THE AGREEMENT IS LIKELY TO RESULT IN LOWER HEALTH CARE COSTS OR IN GREATER ACCESS TO OR QUALITY OF HEALTH CARE THAN WOULD OCCUR WITHOUT THE AGREEMENT. IF THE AUTHORITY DENIES AN APPLICATION FOR A CERTIFICATE FOR AN EXECUTED AGREEMENT, THE AGREEMENT IS VOID UPON THE DECISION OF THE AUTHORITY NOT TO ISSUE THE CERTIFICATE. PARTIES TO A VOID AGREEMENT MAY NOT IMPLEMENT OR CARRY OUT THE AGREEMENT.

(3) THE AUTHORITY SHALL DENY THE APPLICATION FOR A CERTIFICATE OR ISSUE A CERTIFICATE WITHIN 90 DAYS OF RECEIPT

OF A COMPLETED APPLICATION.

NEW SECTION. SECTION 40. RECONSIDERATION BY AUTHORITY.

(1) IF THE AUTHORITY DENIES AN APPLICATION AND REFUSES TO ISSUE A CERTIFICATE, A PARTY TO THE AGREEMENT MAY REQUEST THAT THE AUTHORITY RECONSIDER ITS DECISION. THE AUTHORITY SHALL RECONSIDER ITS DECISION IF THE PARTY APPLYING FOR RECONSIDERATION SUBMITS THE REQUEST TO THE AUTHORITY IN WRITING WITHIN 30 CALENDAR DAYS OF THE AUTHORITY'S DECISION TO DENY THE INITIAL APPLICATION.

(2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE APPLICATION FOR RECONSIDERATION. THE HEARING MUST BE HELD WITHIN 30 DAYS OF RECEIPT OF THE REQUEST FOR RECONSIDERATION UNLESS THE PARTY APPLYING FOR RECONSIDERATION AGREES TO A HEARING AT A LATER TIME. THE HEARING MUST BE HELD PURSUANT TO 2-4-604.

(3) THE AUTHORITY SHALL MAKE A DECISION TO DENY THE APPLICATION OR TO ISSUE THE CERTIFICATE WITHIN 30 DAYS OF THE CONCLUSION OF THE HEARING REQUIRED BY SUBSECTION (2). THE DECISION OF THE AUTHORITY MUST BE PART OF WRITTEN FINDINGS OF FACT AND CONCLUSIONS OF LAW SUPPORTING THE DECISION. THE FINDINGS, CONCLUSIONS, AND DECISION MUST BE SERVED UPON THE APPLICANT FOR RECONSIDERATION.

NEW SECTION. SECTION 41. REVOCATION OF CERTIFICATE BY AUTHORITY. (1) THE AUTHORITY SHALL REVOKE A CERTIFICATE PREVIOUSLY GRANTED BY IT IF THE AUTHORITY DETERMINES THAT

1 THE COOPERATIVE AGREEMENT IS NOT RESULTING IN LOWER HEALTH
 2 CARE COSTS OR GREATER ACCESS TO OR QUALITY OF HEALTH CARE
 3 THAN WOULD OCCUR IN ABSENCE OF THE AGREEMENT.

4 (2) A CERTIFICATE MAY NOT BE REVOKED BY THE AUTHORITY
 5 WITHOUT GIVING NOTICE AND AN OPPORTUNITY FOR A HEARING
 6 BEFORE THE AUTHORITY AS FOLLOWS:

7 (A) WRITTEN NOTICE OF THE PROPOSED REVOCATION MUST BE
 8 GIVEN TO THE PARTIES TO THE AGREEMENT FOR WHICH THE
 9 CERTIFICATE WAS ISSUED AT LEAST 120 DAYS BEFORE THE
 10 EFFECTIVE DATE OF THE PROPOSED REVOCATION.

11 (B) A HEARING MUST BE PROVIDED PRIOR TO REVOCATION IF A
 12 PARTY TO THE AGREEMENT SUBMITS A WRITTEN REQUEST FOR A
 13 HEARING TO THE AUTHORITY WITHIN 30 CALENDAR DAYS AFTER
 14 NOTICE IS MAILED TO THE PARTY UNDER SUBSECTION (2)(A).

15 (C) WITHIN 30 CALENDAR DAYS OF RECEIPT OF THE REQUEST
 16 FOR A HEARING, THE AUTHORITY SHALL HOLD A PUBLIC HEARING TO
 17 DETERMINE WHETHER OR NOT TO REVOKE THE CERTIFICATE. THE
 18 HEARING MUST BE HELD IN ACCORDANCE WITH 2-4-604.

19 (3) THE AUTHORITY SHALL MAKE ITS FINAL DECISION AND
 20 SERVE THE PARTIES WITH WRITTEN FINDINGS OF FACT AND
 21 CONCLUSIONS OF LAW IN SUPPORT OF ITS DECISION WITHIN 30 DAYS
 22 AFTER THE CONCLUSION OF THE HEARING OR, IF NO HEARING IS
 23 REQUESTED, WITHIN 30 DAYS OF THE DATE OF EXPIRATION OF THE
 24 TIME TO REQUEST A HEARING.

25 (4) IF A CERTIFICATE OF PUBLIC ADVANTAGE IS REVOKED BY

1 THE AUTHORITY, THE AGREEMENT FOR WHICH THE CERTIFICATE WAS
 2 ISSUED IS TERMINATED.

3 NEW SECTION. SECTION 42. APPEAL. A PARTY TO A
 4 COOPERATIVE AGREEMENT MAY APPEAL, IN THE MANNER PROVIDED IN
 5 TITLE 2, CHAPTER 4, PART 7, A FINAL DECISION BY THE
 6 AUTHORITY TO DENY AN APPLICATION FOR A CERTIFICATE OR A
 7 DECISION BY THE AUTHORITY TO REVOKE A CERTIFICATE. A
 8 REVOCATION OF A CERTIFICATE PURSUANT TO [SECTION 41] DOES
 9 NOT BECOME FINAL UNTIL THE TIME FOR APPEAL HAS EXPIRED. IF A
 10 DECISION TO REVOKE A CERTIFICATE IS APPEALED, THE DECISION
 11 IS STAYED PENDING RESOLUTION OF THE APPEAL BY THE COURTS.

12 NEW SECTION. SECTION 43. RECORD OF AGREEMENTS TO BE
 13 KEPT. THE AUTHORITY SHALL KEEP A COPY OF COOPERATIVE
 14 AGREEMENTS FOR WHICH A CERTIFICATE IS IN EFFECT PURSUANT TO
 15 [SECTIONS 37 THROUGH 44]. A PARTY TO A COOPERATIVE AGREEMENT
 16 WHO TERMINATES THE AGREEMENT SHALL NOTIFY THE AUTHORITY IN
 17 WRITING OF THE TERMINATION WITHIN 30 DAYS AFTER THE
 18 TERMINATION.

19 NEW SECTION. SECTION 44. RULEMAKING. THE AUTHORITY
 20 SHALL ADOPT RULES TO IMPLEMENT [SECTIONS 37 THROUGH 43]. THE
 21 RULES SHALL INCLUDE RULES:

22 (1) SPECIFYING THE FORM AND CONTENT OF APPLICATIONS FOR
 23 A CERTIFICATE;

24 (2) SPECIFYING NECESSARY DETAILS FOR RECONSIDERATION OF
 25 DENIAL OF CERTIFICATES, REVOCATIONS OF CERTIFICATES,

1 HEARINGS REQUIRED OR AUTHORIZED BY [SECTIONS 37 THROUGH 43],
 2 AND APPEALS; AND
 3 (3) TO EFFECT THE ACTIVE SUPERVISION BY THE AUTHORITY
 4 OF AGREEMENTS BETWEEN HEALTH CARE FACILITIES. THESE RULES
 5 MAY INCLUDE REPORTING REQUIREMENTS FOR PARTIES TO AN
 6 AGREEMENT FOR WHICH A CERTIFICATE IS IN EFFECT.

7 NEW SECTION. Section 45. Codification instructions.
 8 (1) [Sections 1 through 20 AND 37 THROUGH 44] are intended
 9 to be codified as an integral part of Title 50, and the
 10 provisions of Title 50 apply to [sections 1 through 20 AND
 11 37 THROUGH 44].

12 (2) [Sections 22 through 36] are intended to be
 13 codified as an integral part of Title 33, and the provisions
 14 of Title 33 apply to [sections 22 through 36].

15 NEW SECTION. SECTION 46. SEVERABILITY. IF A PART OF
 16 [THIS ACT] IS INVALID, ALL VALID PARTS THAT ARE SEVERABLE
 17 FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS
 18 ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART
 19 REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE
 20 SEVERABLE FROM THE INVALID APPLICATIONS.

21 NEW SECTION. Section 47. Effective dates. (1)
 22 [Sections 1 through 20~~7~~ AND 44 THROUGH 46 and this
 23 section] are effective on passage and approval.

24 (2) [Section 21] is effective July 1, 1996.

25 (3) [Sections 22 through 28, 35, AND 36] are effective

1 January 1, 1994.

2 (4) [SECTIONS 30 THROUGH 34] ARE EFFECTIVE JULY 1,
 3 1993.

-End-

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MINUTES

MONTANA SENATE 53rd LEGISLATURE - REGULAR SESSION

CONFERENCE COMMITTEE ON SENATE BILL 285

Call to Order: By Eve Franklin, Chair, on April 16, 1993, at
11:00 a.m.

ROLL CALL

Members Present:

Senator Eve Franklin, Chair (D)
Senator Robert "Bob" Brown (R)
Senator Dorothy Eck (D)
Representative Thomas Nelson (R)
Representative Sheila Rice (D)
Representative Bruce Simon (R)

Members Excused: None.

Members Absent: None.

Staff Present: Kristie Wolter, Committee Secretary
David Niss, Legislative Council

Discussion:

Senator Franklin opened the floor to discussion on amendments to SB 285. She stated the first amendment to be addressed would be the amendment offered by the Auditor (Exhibit #1).

Frank Cote, Deputy Insurance Commissioner, stated the amendment was offered by the Montana Bankers Association (MBA) and would allow the Bankers Association to exclude themselves from the small group reform. He stated the amendment would allow the MBA to continue to exclude themselves from small group reform as long as they do not deny benefits to any individual who applies for coverage. He stated if there is a small group who applies to the MBA for group insurance, the MBA must take the group and would not be able to exclude a non-healthy person from coverage.

Senator Franklin asked Mr. Cote if the amendment would be consistent with the small group parameters. Mr. Cote stated it would be.

John Cadby, MBA, stated he had no knowledge of the amendments. He stated he would like to know if the MBA could reject a bank in its totality. He stated he had no objection to taking all of the employees, but he would like the ability to reject a bank with high risk employees. He stated he would like the amendment to be

changed to say "we cannot deny coverage to any employee of the members who apply for coverage".

Representative Simon asked Mr. Cadby why the MBA would deny an association employee membership is a health care group. Mr. Cadby stated a member of the association would be denied for risk management and underwriting control reasons and to protect the participants already in the group. Mr. Cadby stated the policy of the MBA as a group must meet underwriting provisions before entering into the health care group. He stated if a group chooses to leave the plan, they are not allowed to rejoin for 18 months. He stated the reason for the 18 month limitation is to limit employers from jumping from one plan to another. Mr. Cadby stated the purpose of a group health plan is to provide stability for the group. He stated a group may be denied if one of the members has a very serious medical problem or history.

Frank Cote stated the Committee has the right to allow for exclusion of groups. He stated the Auditors office was concerned with people being excluded from coverage if they apply with a group.

Motion/Vote:

Senator Franklin moved HB 285 be AMENDED (Exhibit #1). The motion FAILED by Roll Call Vote.

Discussion:

Senator Franklin stated the Committee would consider the second amendment (Exhibit #2). She stated the amendment would remove the amendments dealing with market control language. She stated she had a concern with this amendment because it would be outside of the scope of what the original text intended. She stated there was some confusion as to the meaning of the text.

Peter Blouke, Department of Social and Rehabilitative Services, stated he had concern with the language as it relates to the Medicaid program. He stated his department is currently instituting a "Passport to Health" program which is a managed care system for Medicaid recipients. He stated under the new program, the Medicaid clients must identify a primary care physician and stay with that physician. He stated the new system would prevent "doctor shopping" which would help keep health care costs down. Mr. Blouke stated the language in this amendment may create problems with the federal regulations which relate to Medicaid. He stated the discussion with the Clinton Administration plan will have a "fee for service" component and will allow for freedom of choice. He stated SB 285 would be "cleaner" without the language.

Senator Eck stated she did not understand the amendment and she did not see any advantage to having the language in SB 285.

Motion:

Senator Brown moved HB 285 be AMENDED (Exhibit #2).

Discussion:

Representative Simon stated the amendment was offered for the purpose of ensuring a market-based system. He stated he did not feel certain the amendments would provide for a market-based system.

Vote:

The motion CARRIED by Roll Call Vote.

Discussion:

Senator Franklin stated the Committee would address the amendment which dealt with the assessment formula (Exhibit #3). She stated the non-profit, self-insured had to be included in the assessment formula. She supplied copies from the Billings Education Association and Billings Public Schools (Exhibits #4 and #5). She stated this amendment would exclude public entities from assessment.

Tom Bilodeau, Research Director, Montana Education Association, stated government entities do not have access to alternative revenue beyond what they are budgeted. He stated the school systems are capped in the current budget. Mr. Bilodeau stated the amendment would allow the public entities which do not currently have budgeted monies available for a potential assessment to be exempted from the assessment.

Tanya Ask, Blue Cross/Blue Shield, stated she opposed the proposed amendment. She stated the assessment formula was to allow a broad base for assessment. Ms. Ask stated the assessment would affect people whose insured product is covered by the Montana Insurance Code. She stated the assessment would be against all insured products and would also be against governmental subdivisions of the State of Montana which may be self-funded. She stated the assessment would also cover individual products. Ms. Ask stated the idea behind the assessment is to spread the assessment to help individuals who do not have access to health care.

Representative Simon asked Larry Akey, Montana Association of Life Underwriters, how the assessment formula works and what affect it may have on the state groups. Mr. Akey stated there was no actuarial estimate of what the maximum net program loss would be if the assessment formula were applied. Mr. Akey stated the numbers run by Blue Cross/Blue Shield were based on experience rating. He stated the maximum number of net program loss which might be seen would be around \$500,000. He stated the

\$500,000 loss was covered by a federal fund appropriation. Mr. Akey stated 300,000 lives would be covered by the \$500,000. He stated the net loss per each life insured would be \$1.67. He stated the loss to each entity would be figured by multiplying the number of lives insured by \$1.67 per life. He stated Montana has 28,000 lives insured and the loss would be around \$45,000, half of which would be covered by the General Fund.

Senator Franklin asked Mr. Akey to place the \$1.67 in context. Mr. Akey stated the \$1.67 is what would occur if the reinsurance pool does not get enough money from premiums to meet all the risks associated with the policies. Mr. Akey stated the assessments would be made against the people who are defined as assessable carriers. He stated there are approximately 300,000 people insured by the assessable carriers. He then stated the maximum likely net-program loss is \$500,000 upon assessment of the assessable carriers. Mr. Akey stated the \$1.67 is derived from the process of dividing 300,000 lives into \$500,000 of total net-program loss, and the \$1.67 is a per year figure.

Representative Simon asked Mr. Akey if there would be an increase from the \$1.67 if the assessable carriers were to be excluded. Mr. Akey stated he had no figures on which to base an estimate. He stated the narrower the base is, the greater the increase in the cost to the remaining members.

Senator Eck asked Mr. Akey if all of the self-insured who are going to be excluded would insure everyone who is an employee and if they could exclude anyone drawing on the reinsurance pool. Mr. Akey stated the exclusions vary from plan to plan.

Representative Scott McCulloch stated the contract negotiations with the school system employees mandate the insurance coverage as a condition of employment. He stated the reinsurance pool is inaccessible to the employees of the school system because the contract negotiated was for a two year period. He stated because the reinsurance pool was inaccessible to his group, they should not have to be subject to assessment. He stated only the employed are mandated to have the insurance coverage.

Representative Nelson asked Mr. McCulloch if additional parties to the insurance policies must supply health evidence. Mr. McCulloch stated he did not believe they did. He stated the policies were supplemented by employee contributions and the addition of dependents on the policies was optional. He stated the employer pays 100% of the employees premium but any additional dependents were paid for through employee contribution.

Representative Rice asked Tom Hopgood if not only the large group plans, but also the individual plans, would be covered by the proposed amendment. Mr. Hopgood stated she was correct.

Senator Franklin stated there is no place in the amendment for the non-profit, self-insured groups to absorb the costs.

Motion/Vote:

Senator Eck moved HB 285 be AMENDED (Exhibit #3). The motion CARRIED by Roll Call Vote.

Discussion:

Senator Franklin stated amendment SB02825.adn (Exhibit #6) was intended to address application of mandated benefits to the basic health benefit package. She stated the House had deleted the inclusion of the mandate for the basic package and this amendment would reverse the deletion.

Representative Nelson clarified there were two plans which would be prepared by the commission, one of which was a basic plan and the other was a more inclusive plan with greater benefits.

Mary McCue, Montana Clinical Health Council, stated her support of the proposed amendment. She stated the amendment would allow for the sale of a basic health plan without the mandates at a lower cost. She stated her group would like the issue of mandates be addressed by the health care authority over a period of a couple of years.

Jim Smith, Montana Psychological Association, stated his support of the amendment. He stated 47% of all the people with health insurance in Montana have small group health insurance plans through their employers. He stated the exclusion of people with mandated benefits would exclude almost half of the people in Montana.

Representative Simon stated the proposed amendment would create options and allow for review of the options available.

Senator Eck stated there will be two levels of care established: a basic plan and a standard plan. She stated the intention was the levels of care would not be inferior to one another. She stated the amendment would give the direction and possibility of keeping the levels of care even.

Motion/Vote:

Senator Eck moved HB 285 be AMENDED (Exhibit #6). The motion FAILED on Roll Call Vote.

Motion:

Representative Nelson moved HB 285 be AMENDED (Exhibit #7).

Discussion:

Jim Ahrens, President, Montana Hospital Association, stated the proposed amendment (Exhibit #7) would strike a reference to the certificate of need as a standard to determine how the authority would view capital expenditures. He stated the amendment would say "the authority shall consider adopting a system to control capital expenditures". He stated there are many ways to consider capital expenditures and certificate of need is not necessary.

Senator Franklin stated she had to resist the amendment because there were other factors outside of the certificate of need process. She stated the amendment was added in the House and it was sensible to include all of the major facilities in examination.

Senator Eck stated the Governor had not made specific recommendations as to how to address the examinations for cost control. She stated there was a lot of support for the cost control measures to not include the certificate of need because the process did not work.

Jim Ahrens stated Section 16 of SB 285 addressed the study of certificate of need. Mr. Ahrens stated the section would include hospitals. He stated the study would be done, but the certificate of need process did not have to be a standard for the process.

Representative Nelson stated the adoption of the amendment would still allow the Commission to apply the certificate of need as a standard if it chose to or would allow them to use some other means to measure the standards.

Representative Simon stated the certificate of need was no different than the language which makes for the consideration of a system to control capital expenditures. He stated the amendment did not hold any water and would not change SB 285 one way or the other.

Senator Brown stated there would be no harm in adopting the amendment because all it would do would be to give a level of comfort to the hospitals.

Representative Rice stated the certificate of need process had enough negative connotations and the amendment would allow for the adoption of a procedure to control capital expenditures without specifying one kind of capital expenditure control mechanism.

Senator Eck stated the certificate of need is a red flag.

Vote:

The motion CARRIED on Roll Call Vote.

Motion/Vote:

Senator Brown the first amendment (Exhibit #1) be RECONSIDERED.

Motion/Vote:

Senator Brown moved HB 285 be AMENDED (Exhibit #1). The motion CARRIED on Roll Call Vote.

Motion/Vote:

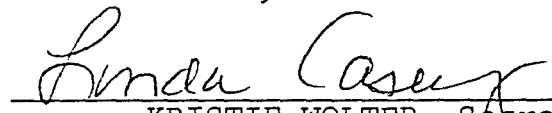
Representative Simon moved the COMMITTEE REPORT be ADOPTED. The motion CARRIED UNANIMOUSLY.

ADJOURNMENT

Adjournment: 11:55 a.m.



SENATOR EVE FRANKLIN, Chair



KRISTIE WOLTER, Secretary

EF/klw

Conference Committee
on Senate Bill No. 285
Report No. 1, April 19, 1993

April 20, 1993
Page 2 of 2

Page 1 of 2

Mr. President and Mr. Speaker:

We, your Conference Committee on Senate Bill No. 285, met and considered: House amendments to Senate Bill No. 285. We recommend that Senate Bill No. 285 (reference copy - salmon) be amended as follows:

1. Page 7, lines 9 and 10.

Strike: "SIMILAR TO THE CERTIFICATE OF NEED SYSTEM BY WHICH"

Insert: "to control"

Strike: "ARE CONTROLLED"

2. Page 7, lines 16 through 21.

Strike: subsection (F) in its entirety

3. Page 15, lines 19 and 20.

Strike: "EACH STATEWIDE PLAN MUST INCLUDE INCENTIVES FOR MARKET CONTROL."

4. Page 17, lines 14 and 15.

Strike: " PROVIDE MARKET CONTROL,"

5. Page 17, line 22.

Strike: "(P) INCENTIVES FOR MARKET CONTROL;"

Renumber: subsequent subsections

6. Page 19, line 9.

Strike: "AND AN INDIVIDUAL'S CHOICE OF SERVICES"

7. Page 40, line 8.

Following: "INSURANCE,"

Insert: "excluding"

8. Page 46, line 22.

Following: "OR"

Insert: "(a)"

9. Page 46, line 24.

Following: "36]"

Insert: ";

(b) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group;"

Following: "AND"

Insert: "

(c)"

ADOPT

REJECT

10. Page 47, line 1.

Following: "GROUP"

Insert: " ,"

And that this Conference Committee report be adopted.

For the Senate:

Ever Franklin
Senator Franklin, Chair

B. C. Brown
Senator Brown

Dorothy Eck
Senator Eck

For the House:

Bruce Simon
Representative Simon, Chair

Tom Nelson
Representative T. Nelson

Steve
Representative S. Rice

m-
Amd. Coord.

W
Sec. of Senate

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,

BIANCHI, HARPER, JERGSON, RYAN, LYNCH, HALLIGAN,

VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB,

CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE,

COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE,

DOWELL, RUSSELL, STANFORD, TUSS, DOLEZAL, DOHERTY,

PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN,

WELDON, KENNEDY, WILSON, BARTLETT,

SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY; PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY; REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN; REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING; ~~REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON LONG-TERM CARE, REQUIRING THE AUTHORITY TO ESTABLISH HEALTH PLANNING REGIONS AND BOARDS~~ REQUIRING DEVELOPMENT OF UNIFORM CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A UNIFIED HEALTH CARE DATA BASE; ~~PROVIDING FOR HEALTH INSURANCE REFORM~~ REQUIRING HEALTH INSURER COST MANAGEMENT PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS STATE HEALTH PLANNING; PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY; AMENDING SECTION 50-15-101 50-1-201, MCA; AND PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

~~A statement of legislative intent is required for this bill because {section 10} requires the Montana health care authority to adopt rules establishing a maximum of five health care planning regions, to establish regional health care planning boards within those regions, and to establish a procedure for selection of regional board members. The legislature intends that the rules establishing the health care planning regions be based primarily upon the geographic health care referral patterns by which health care providers refer patients to specialists or larger health care facilities. These rules should also consider communication~~

and transportation patterns and natural barriers to these patterns. The rules establishing the boards must specify the number of members, any relevant qualifications, and the operations and duties of the boards and must provide for a funding mechanism by grant from the authority. The procedure for selection of the board members must provide for public notice of the selection process.

A statement of intent is also required because {section 12} requires the authority to adopt rules relating to the unified health care data base. The authority's rules must specify in comprehensive detail what information is required to be provided by health care providers and the times at which the information is to be provided. The rules must also provide for audit procedures to determine the accuracy of the filed data. The confidentiality provisions must be consistent with other state laws governing the confidentiality of public records, including medical records, and must apply to employees of the authority and to others receiving or using records in the data base.

A statement of intent is also required because {section 13} requires the commissioner of insurance to adopt rules governing small employer group health plans in determining the basic benefits package, the commissioner shall make objective determinations, supported by available data, concerning the type of benefits required and shall determine

that the benefits to be required are cost effective. (1) A STATEMENT OF LEGISLATIVE INTENT IS REQUIRED FOR THIS BILL BECAUSE:

{1}(A) [SECTION 4] AUTHORIZES THE MONTANA HEALTH CARE AUTHORITY TO ADOPT RULES NECESSARY TO IMPLEMENT [SECTIONS 1 THROUGH 20]. IN ADDITION TO THOSE RULEMAKING MATTERS ADDRESSED BELOW, THE AUTHORITY MAY ADOPT RULES GOVERNING SUCH MATTERS AS ITS MEETINGS, PUBLIC HEARINGS, AND RULES OF PROCEDURE AND RULES OF ETHICAL CONDUCT GOVERNING ITS MEMBERS.

{2}(B) [SECTION 17] REQUIRES THE MONTANA HEALTH CARE AUTHORITY TO ADOPT RULES TO ESTABLISH REGIONAL HEALTH CARE PLANNING BOARDS WITHIN THE HEALTH CARE PLANNING REGIONS ESTABLISHED IN [SECTION 17] AND TO ESTABLISH A PROCEDURE FOR SELECTION OF REGIONAL BOARD MEMBERS. THE RULES ESTABLISHING THE BOARDS MUST SPECIFY THE NUMBER OF MEMBERS, ANY RELEVANT QUALIFICATIONS, AND THE OPERATIONS AND DUTIES OF THE BOARDS AND MUST PROVIDE FOR A FUNDING MECHANISM BY GRANT FROM THE AUTHORITY. IN ADDITION, THE RULES MUST PROVIDE FOR CONSIDERATION OF A BALANCE BETWEEN RURAL AND URBAN INTERESTS IN THE SELECTION OF REGIONAL BOARD MEMBERS. THE PROCEDURE FOR SELECTION OF THE BOARD MEMBERS MUST PROVIDE FOR PUBLIC NOTICE OF THE SELECTION PROCESS.

{3}(C) [SECTION 10] GRANTS THE COMMISSIONER OF INSURANCE THE AUTHORITY TO ADOPT RULES SPECIFYING UNIFORM

1 HEALTH INSURANCE CLAIM FORMS AND PROCEDURES. THE FORMS
 2 SHOULD BE BASED UPON EXISTING FORMATS, BE AS SHORT AS
 3 POSSIBLE, AND BE COMPATIBLE WITH ELECTRONIC DATA
 4 TRANSMISSION.

5 (4)(D) [SECTION 19] REQUIRES THE AUTHORITY TO ADOPT
 6 RULES RELATING TO THE UNIFIED HEALTH CARE DATA BASE. THE
 7 AUTHORITY'S RULES MUST SPECIFY IN COMPREHENSIVE DETAIL WHAT
 8 INFORMATION IS REQUIRED TO BE PROVIDED BY HEALTH CARE
 9 PROVIDERS AND THE TIMES AT WHICH THE INFORMATION IS TO BE
 10 PROVIDED. THE RULES MUST ALSO PROVIDE FOR AUDIT PROCEDURES
 11 TO DETERMINE THE ACCURACY OF THE FILED DATA. THE
 12 CONFIDENTIALITY PROVISIONS MUST BE CONSISTENT WITH OTHER
 13 STATE LAWS GOVERNING THE CONFIDENTIALITY OF PUBLIC RECORDS,
 14 INCLUDING MEDICAL RECORDS, AND MUST APPLY TO EMPLOYEES OF
 15 THE AUTHORITY AND TO OTHERS RECEIVING OR USING RECORDS IN
 16 THE DATA BASE.

17 (5)(E) [SECTIONS 23, 26, 27, 30, 31, AND 34 THROUGH 36]
 18 REQUIRE THE COMMISSIONER OF INSURANCE TO ADOPT RULES
 19 GOVERNING SMALL EMPLOYER GROUP HEALTH PLANS. IN DETERMINING
 20 THE BASIC BENEFITS PACKAGE, THE COMMISSIONER SHALL MAKE
 21 OBJECTIVE DETERMINATIONS, SUPPORTED BY AVAILABLE DATA,
 22 CONCERNING THE TYPE OF BENEFITS REQUIRED AND SHALL DETERMINE
 23 THAT THE BENEFITS TO BE REQUIRED ARE COST-EFFECTIVE PURSUANT
 24 TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE
 25 COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION

1 PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH
 2 CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE
 3 THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY
 4 IF THE COMMISSIONER DETERMINES THAT THE ADDITIONAL CLASSES
 5 WOULD ENHANCE THE EFFICIENCY AND FAIRNESS OF THE SMALL
 6 EMPLOYER HEALTH INSURANCE MARKET. THE COMMISSIONER IS
 7 REQUIRED UNDER THE ACT TO ADOPT RULES TO IMPLEMENT AND
 8 ADMINISTER THE ACT.

9 (F) [SECTION 44] REQUIRES THE AUTHORITY TO ADOPT RULES
 10 IMPLEMENTING [SECTIONS 37 THROUGH 44]. THE RULES ADOPTED BY
 11 THE AUTHORITY MUST SPECIFY THE FORM AND CONTENT OF
 12 APPLICATIONS FOR CERTIFICATES OF PUBLIC ADVANTAGE; DETAILS
 13 OF THE RECONSIDERATION, REVOCATION, HEARING, AND APPEAL
 14 PROCESSES; AND OTHER MATTERS AS THE AUTHORITY DETERMINES
 15 NECESSARY. THE RULES THAT ARE ADOPTED BY THE AUTHORITY MUST
 16 ALSO PROVIDE THE AUTHORITY WITH DIRECT SUPERVISION AND
 17 CONTROL OVER THE IMPLEMENTATION OF COOPERATIVE AGREEMENTS
 18 BETWEEN FACILITIES.

19 (2) IN PREPARING THE PLAN REQUIRED BY [SECTION 5], THE
 20 AUTHORITY SHALL CONSIDER THE FOLLOWING MATTERS FOR THE
 21 FOLLOWING FEATURES OF THE PLAN:

22 (A) A UNIFIED HEALTH CARE BUDGET. THE AUTHORITY SHALL
 23 CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE BUDGET BASED
 24 UPON THE BUDGETS SUBMITTED BY THE REGIONAL HEALTH CARE
 25 PLANNING BOARDS.

(B) CAPS FOR PROVIDER EXPENDITURES. THE AUTHORITY SHALL CONSIDER A PROCESS FOR ADOPTING MANDATORY LIMITS ON PROVIDER EXPENSES, INCLUDING FEES AND SALARIES.

(C) GLOBAL BUDGETING FOR ALL HEALTH CARE SPENDING. THE AUTHORITY SHALL CONSIDER ADOPTING A BUDGETING PROCESS, WITH PUBLIC INVOLVEMENT, BY WHICH A UNIFIED HEALTH CARE BUDGET IS DETERMINED.

(D) CONTROLLED CAPITAL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING A SYSTEM ~~SIMILAR TO THE CERTIFICATE OF NEED SYSTEM BY WHICH~~ TO CONTROL CAPITAL EXPENDITURES ARE CONTROLLED.

(E) BINDING CAP ON OVERALL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING MANDATORY LIMITS ON ALL TYPES OF EXPENDITURES OF HEALTH CARE PROVIDERS, INCLUDING CAPITAL EXPENDITURES, SMALL EQUIPMENT PURCHASES, PERSONNEL COSTS, AND ALL OTHER TYPES OF OPERATING COSTS.

~~(F) MARKET CONTROL. THE AUTHORITY SHALL CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE PLAN BASED UPON THE PREFERENCES AND NEEDS OF THE HEALTH CARE CONSUMER. INCENTIVES FOR MARKET CONTROL SHOULD INCLUDE MECHANISMS THAT ENCOURAGE HEALTH CARE PROVIDERS TO RESPOND TO PREFERENCES AND NEEDS OF HEALTH CARE CONSUMERS.~~

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

(Refer to Introduced Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. Section 1. State health care policy. (1)

It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health care resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(E) FACILITATE UNIVERSAL ACCESS TO HEALTH SCIENCES INFORMATION;

(F) PROMOTE RATIONAL ALLOCATION OF HEALTH CARE RESOURCES IN THE STATE; AND

(G) FACILITATE UNIVERSAL ACCESS TO PREVENTIVE AND MEDICALLY NECESSARY HEALTH CARE.

(3) IT IS FURTHER THE POLICY OF THE STATE OF MONTANA THAT REGARDLESS OF WHETHER OR WHAT FORM OF A HEALTH CARE ACCESS PLAN IS ADOPTED BY THE LEGISLATURE, THE HEALTH CARE AUTHORITY, HEALTH CARE PROVIDERS, AND OTHER PERSONS INVOLVED IN THE DELIVERY OF HEALTH CARE SERVICES NEED TO INCREASE THEIR EMPHASIS ON THE EDUCATION OF CONSUMERS OF HEALTH CARE SERVICES. CONSUMERS SHOULD BE EDUCATED CONCERNING THE HEALTH CARE SYSTEM, PAYMENT FOR SERVICES, ULTIMATE COSTS OF HEALTH CARE SERVICES, AND THE BENEFIT TO CONSUMERS GENERALLY OF PROVIDING ONLY SERVICES TO THE CONSUMER THAT ARE REASONABLE AND NECESSARY.

NEW SECTION. Section 2. Definitions. For the purposes of [sections 1 through 20 AND 37 THROUGH 44], the following definitions apply:

(1) "Authority" means the Montana health care authority created by [section 3].

(2) "Board" means one of the regional health care planning boards created pursuant to [section 17].

(3) "CERTIFICATE OF PUBLIC ADVANTAGE" OR "CERTIFICATE"

MEANS A WRITTEN CERTIFICATE ISSUED BY THE AUTHORITY AS EVIDENCE OF THE AUTHORITY'S INTENTION THAT THE IMPLEMENTATION OF A COOPERATIVE AGREEMENT, WHEN ACTIVELY SUPERVISED BY THE AUTHORITY, RECEIVE STATE ACTION IMMUNITY FROM PROSECUTION AS A VIOLATION OF STATE OR FEDERAL ANTITRUST LAWS.

(4) "COOPERATIVE AGREEMENT" OR "AGREEMENT" MEANS A WRITTEN AGREEMENT BETWEEN TWO OR MORE HEALTH CARE FACILITIES FOR THE SHARING, ALLOCATION, OR REFERRAL OF PATIENTS; PERSONNEL; INSTRUCTIONAL PROGRAMS; EMERGENCY MEDICAL SERVICES; SUPPORT SERVICES AND FACILITIES; MEDICAL, DIAGNOSTIC, OR LABORATORY FACILITIES OR PROCEDURES; OR OTHER SERVICES CUSTOMARILY OFFERED BY HEALTH CARE FACILITIES.

(5) "Data base" means the unified health care data base created pursuant to [section 19].

(6) "HEALTH CARE" INCLUDES BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

(7) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

{5}{8} "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

{6}{9} "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

{7}{10} "Management plan" means the health care resource management plan required by [section 8].

{8}{11} "Region" means one of the health care planning regions created pursuant to [section 17].

{9}{12} "Statewide plan" means one of the statewide universal health care access plans for access to health care required by [section 5].

NEW SECTION. Section 3. Montana health care authority
-- allocation -- membership. (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members

appointed by the governor. At least one member must represent consumer organizations. Members of the authority must be appointed as follows:

(a) Within 30 days of [the effective date of this section], the majority SPEAKER and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The majority SPEAKER and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(b) Within 30 days of [the effective date of this section], the majority PRESIDENT and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The majority PRESIDENT and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from

those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) THE ATTORNEY GENERAL IS AN EX OFFICIO, NONVOTING MEMBER OF THE AUTHORITY ONLY FOR THE PURPOSE OF THE AUTHORITY'S APPROVAL OR DENIAL OF CERTIFICATES OF PUBLIC ADVANTAGE, SUPERVISION OF COOPERATIVE AGREEMENTS, AND REVOCATION OF CERTIFICATES OF PUBLIC ADVANTAGE PURSUANT TO [SECTIONS 37 THROUGH 44].

(9) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

NEW SECTION. **Section 4. Administration of health care authority -- reports -- compensation.** (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The

executive director is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with 50-1-201 and [sections 1 through 20];

(b) adopt rules necessary to implement [sections 1 through 20]; and

(c) enter into contracts and--perform---other---acts

1 necessary to accomplish the purposes of [sections 1 through
2 20].

3 (5) The authority shall report to the legislature and
4 the governor at least twice a year on its progress since the
5 last report in fulfilling the requirements of [sections 1
6 through 20]. Reports may be provided in a manner similar to
7 5-11-210 or in another manner determined by the authority.

8 (6) Members of the authority must be paid and
9 reimbursed as provided in 2-15-124.

10 (7) The authority shall make grants to the boards for
11 the operation of the boards. The authority shall provide for
12 uniform procedures for grant applications and budgets of the
13 boards.

14 NEW SECTION. Section 5. Statewide universal access
15 plans required. (1) On or before October 1, 1994, the
16 authority shall submit a report to the legislature that
17 contains the authority's recommendation for a statewide
18 universal health care access plan based on a single payor
19 system and a recommendation for a statewide universal access
20 plan based on a regulated multiple payor system. EACH
21 STATEWIDE-PLAN-MUST-INCLUDE-INCENTIVES-FOR-MARKET-CONTROL.
22 Each statewide plan must contain recommendations that, if
23 implemented, would provide for universally accessible,
24 medically necessary, and preventive health care by October
25 1, 1995. Both plans must be voted on by the 1995 legislature

1 ~~no-later-than-45-days-from-the-first-day-of-the-1995~~
2 ~~legislative-session.~~ The legislature may return one or both
3 plans to the authority for further development.

4 (2) For purposes of this section:

5 (a) a single payor system is a method of financing
6 health CARE services predominantly through public funds so
7 that each resident of Montana receives a uniform set of
8 benefits as established through statute or administrative
9 rule. Policies governing all aspects of the management of
10 the single payor system would reside with state government,
11 and benefits must be administered by a single entity.

12 (b) a regulated multiple payor system is a method of
13 financing health CARE services through a mix of public and
14 private funds so that each resident of Montana receives a
15 uniform set of benefits as established by statute or
16 administrative rule. State government has responsibility for
17 regulating the multiple entities that provide benefits to
18 residents, including regulations for enrollment, change in
19 premium rates, payment rates to providers, and aggregate
20 health expenditures.

21 NEW SECTION. Section 6. Features of statewide plans.
22 (1) Each statewide plan under [section 5] must contain the
23 features required by [sections 7 through 9 and 11] and this
24 section.

25 (2) Each statewide plan must include:

1 (a) guaranteed access to health care services for all
 2 residents of Montana;
 3 (b) a uniform system of health care benefits;
 4 (c) a unified health care budget;
 5 (d) portability of coverage, regardless of job status;
 6 (e) a broad-based, public or private financing
 7 mechanism to fund health care services;
 8 (F) CONSIDERATION OF THE LIMITATIONS OF PUBLIC FUNDING;
 9 ~~(f)~~(G) a system capped for provider expenditures;
 10 ~~(g)~~(H) global budgeting for all health care spending;
 11 ~~(h)~~(I) controlled capital expenditures;
 12 ~~(i)~~(J) a binding cap on overall expenditures;
 13 ~~(j)~~(K) policymaking for the system as a whole and
 14 accountability within state government;
 15 ~~(k)~~(L) incentives to be used to contain costs ~~---~~PROVIDE
 16 MARKET-CONTROL and direct resources;
 17 ~~(l)~~(M) administrative efficiencies;
 18 ~~(m)~~(N) the appropriate use of midlevel practitioners,
 19 such as physician's assistants and nurse practitioners;
 20 ~~(n)~~(O) mechanisms for reducing the cost of prescription
 21 drugs, both as part of and as separate from the uniform
 22 benefit plan;
 23 ~~(P)---INCENTIVES-FOR-MARKET-CONTROL~~;
 24 ~~(o)~~(Q)(P) integration, to the extent possible under
 25 federal and state law, of benefits provided under the health

1 care system with benefits provided by the Indian health
 2 service and the United States department of veteran affairs
 3 and benefits provided by the medicare and medicaid programs;
 4 and

5 ~~(p)~~(R)(Q) an actuarially sound estimate of the costs of
 6 implementing the plan through the year 2005.

7 (3) NOTHING IN [SECTIONS 7 THROUGH 9 AND 11] OR THIS
 8 SECTION MAY BE INTERPRETED TO PREVENT MONTANA RESIDENTS FROM
 9 SEEKING HEALTH CARE SERVICES NOT PROVIDED IN EITHER OR BOTH
 10 STATEWIDE PLANS.

11 NEW SECTION. Section 7. Cost containment. (1) The
 12 statewide plans must contain a cost containment component,
 13 INCLUDING ANNUAL COST CONTAINMENT TARGETS. Except as
 14 otherwise provided in this section, each statewide plan must
 15 establish ~~a--target~~ TARGETS for cost containment so that by
 16 1999, the annual average percentage increase in statewide
 17 health care costs does not exceed the average annual
 18 percentage increase in the gross domestic product, as
 19 determined by the U.S. department of commerce, for the 5
 20 preceding years.

21 (2) The authority shall adopt processes and criteria
 22 for responding to exceptional and unforeseen circumstances
 23 that affect the health care system and the target TARGETS
 24 required in subsection (1), including such factors as
 25 population increases or decreases, demographic changes,

costs beyond the control of health care providers, and other factors that the authority considers significant.

(3) The authority shall, AT A MINIMUM, include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis ~~AND-AN-INDIVIDUAL'S-CHOICE-OF-SERVICES~~.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the same rate for the same health care services and items and that reimbursement for services is based predominantly upon the health care service provided rather than upon the discipline of the health care provider.

(d) a method of monitoring compliance with the target TARGETS required in subsection (1);

(e) expenditure targets for health care providers and facilities;

(f) disincentives for exceeding the targets established pursuant to subsection (3)(e), including reduction of reimbursement levels in subsequent years;

(g) reimbursement of health care providers and health

care facilities that is based upon negotiated annual budgets or fees for services; and

(h) a plan by the authority, health care providers, health insurers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

NEW SECTION. **Section 8.** Health care resource management plan. (1) Each statewide plan must contain a health care resource management plan that takes into account the provisions of [section 7]. The management plan must provide for the distribution of health care resources within the regions established pursuant to [section 17] and within the state as a whole, consistent with the principles provided in subsection (2).

(2) The management plan must include:

(a) a statement of principles used in the allocation of resources and in establishing priorities for health services;

(b) identification of the current supply and distribution of:

(i) hospital, nursing home, and other inpatient services;

(ii) home health and mental health services;

(iii) treatment services for alcohol and drug abuse;

(iv) emergency care;

1 (v) ambulatory care services, including primary care
 2 resources;
 3 (vi) nutrition benefits, prenatal benefits, and
 4 maternity care;
 5 (vii) human resources;
 6 (VIII) HEALTH SCIENCES LIBRARY RESOURCES AND SERVICES;
 7 ~~(viii)~~ (IX) major medical equipment; and
 8 ~~(ix)~~ (X) health screening and early intervention
 9 services;
 10 (c) a determination of the appropriate supply and
 11 distribution of the resources and services identified in
 12 subsection (2)(b) and of the mechanisms that will encourage
 13 the appropriate integration of these services on a local or
 14 regional basis. To arrive at a determination, the authority
 15 shall consider the following factors:
 16 (i) the needs of the statewide population, with special
 17 consideration given to the development of health care
 18 services in underserved areas of the state;
 19 (ii) the needs of particular geographic areas of the
 20 state;
 21 (iii) the use of Montana facilities by out-of-state
 22 residents;
 23 (iv) the use of out-of-state facilities by Montana
 24 residents;
 25 (v) the needs of populations with special health care

1 needs;
 2 (vi) the desirability of providing high-quality services
 3 in an economical and efficient manner, including the
 4 appropriate use of midlevel practitioners; and
 5 (vii) the cost impact of these resource requirements on
 6 health care expenditures;
 7 (d) a component that addresses health promotion and
 8 disease prevention and that is prepared by the department of
 9 health and environmental sciences in a format established by
 10 the authority;
 11 (e) incentives to improve access to and use of
 12 preventive care; primary care services, including mental
 13 health services; and community-based care;
 14 (f) incentives for healthy lifestyles;
 15 (g) incentives to improve access to health care in
 16 underserved areas, including:
 17 (i) a system by which the authority may identify
 18 persons with an interest in becoming health care
 19 professionals and provide or assist in providing health care
 20 education for those persons; and
 21 (ii) tax credits and other financial incentives to
 22 attract and retain health care professionals in underserved
 23 areas; and
 24 (h) a component that addresses integration of the plan,
 25 to the extent allowed by state and federal law, with

1 services provided by the Indian health service and by the
2 United States department of veterans affairs and by the
3 medicare and medicaid programs.

4 (3) In adopting the management plan, the authority
5 shall consider the regional health resource plans
6 recommended by regional panels.

7 (4) The management plan must be revised annually in a
8 manner determined by the authority.

9 (5) Prior to adoption of the management plan, the
10 authority shall hold one or more public hearings for the
11 purpose of receiving oral and written comment on a draft
12 plan. After hearings have been concluded, the authority
13 shall adopt the management plan, taking comments into
14 consideration.

15 NEW SECTION. Section 9. Health care billing
16 simplification. (1) Each statewide plan must contain a
17 component providing for simplification and reduction of the
18 costs associated with health care billing. In designing this
19 component, the authority may consider:

20 (a) conversion from paper health care claims to
21 standardized electronic billing; and

22 (b) creating a claims clearinghouse, consisting of a
23 state agency or private entity, to receive claims from all
24 health care providers for compiling, editing, and submitting
25 the claims to payors.

1 (2) The health care billing component must include a
2 method to educate and assist health care providers and
3 payors who will use any health care billing simplification
4 system recommended by the authority.

5 (3) The billing component must provide a schedule for a
6 phasein of any health care billing simplification system
7 recommended by the authority. The schedule must relieve
8 health care providers, payors, and consumers of undue
9 burdens in using the system.

10 NEW SECTION. Section 10. Uniform claim forms and
11 procedures. (1) ~~By January 17, 1994, the~~ THE commissioner of
12 insurance, after consultation with the authority, may adopt
13 by rule uniform health insurance claim forms and uniform
14 standards and procedures for the use of the forms and
15 processing of claims, including the submission of claims by
16 means of an electronic claims processing system.

17 (2) The commissioner may contract with a private or
18 public entity to administer and operate an electronic claims
19 processing system. If the commissioner elects to contract
20 for administration and operation of the system, the
21 commissioner shall award a contract according to Title 18,
22 chapter 4.

23 NEW SECTION. Section 11. Other matters to be included
24 in statewide plans. (1) The statewide plans recommended by
25 the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phase in of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of a system for reducing the use of defensive medicine by adopting practice protocols that would give providers guidelines to follow for specific procedures;

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

(iii) propose any changes, including legislation, that it considers necessary, including measures for compensating victims of tortious injuries.

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be

included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority ~~shall~~ MAY include in its plans legislation IN ADDITION TO [SECTIONS 37 THROUGH 44] that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

NEW SECTION. Section 12. Hearings AVAILABILITY OF PLANS -- HEARINGS on statewide plans. (1) THE AUTHORITY SHALL MAKE COPIES OF THE DRAFT STATEWIDE PLANS WIDELY AVAILABLE AT PUBLIC EXPENSE TO INTERESTED PERSONS AND GROUPS.

(2) The authority shall seek public comment on the

development of each statewide plan required under [section 5]. In seeking public comment on the development of the authority's recommendations for each plan, the authority shall provide extensive, multimedia notice to the public and hold at least one public hearing in each of the health care planning regions established by [section 17]. The hearings must take place before the authority's report is submitted to the legislature. The authority shall consult with health care providers in the development of its recommendations for each statewide plan.

(3) THE AUTHORITY SHALL CONSIDER ORAL AND WRITTEN PUBLIC COMMENTS ON THE STATEWIDE PLANS BEFORE RECOMMENDING THEM TO THE LEGISLATURE.

NEW SECTION. Section 13. State purchasing pool -- reports required. (1) On or before December 15, 1994, and December 15, 1996, the authority shall report to the legislature on establishment of a state purchasing pool, including the number and types of groups and group members participating in the pool, the costs of administering the pool, the savings attributable to participating groups from the operation of the pool, and any changes in legislation considered necessary by the authority.

(2) On or before December 15, 1996, the authority shall report to the legislature its recommendations concerning the feasibility and merits of authorizing the authority to act

as an insurer in pooling risks and providing benefits, including a common benefits plan, to participants of the purchasing pool.

NEW SECTION. Section 14. Study of prescription drug cost and distribution. The authority shall conduct a study of the cost and distribution of prescription drugs in this state. The study must consider the feasibility of various methods of reducing the cost of purchasing and distributing prescription drugs to Montana residents. The study must include the feasibility of establishing a prescription drug purchasing pool for distribution of drugs through pharmacists in this state. The results of the study, including the authority's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1996. If the authority determines that feasible methods are available without need for legislation or appropriations, the authority shall implement that part or those parts of its recommendations.

NEW SECTION. Section 15. Long-term care study and recommendations. (1) The authority shall conduct a study of the long-term care needs of state residents and report to the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996,

after which the authority shall conduct public hearings on its report in each region established under [section 17]. The authority shall present its report to the legislature on or before January 1, 1997.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The authority's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The authority's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana and its citizens over the next 20 years if there is no change in the present accessibility, affordability, or financing of long-term care services in this state.

(4) The authority shall consult with the department of social and rehabilitation services in developing its recommendations under this section.

NEW SECTION. Section 16. Study of certificate of need process. (1) The authority shall conduct a study of the certificate of need process established under Title 50,

chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the authority's recommendation for a single payor health care system required by [section 5]. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for HOSPITALS AND FOR offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

NEW SECTION. Section 17. Health care planning regions and regional planning boards created -- selection -- membership. (1) There are five health care planning regions. Subject to subsection (2), the regions must consist of the following counties:

(a) region I: Sheridan, Daniels, Valley, Phillips, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and

1 Carter;

2 (b) region II: Blaine, Hill, Liberty, Toole, Glacier,
3 Pondera, Teton, Chouteau, and Cascade;

4 (c) region III: Judith Basin, Fergus, Petroleum,
5 Musselshell, Golden Valley, Wheatland, Sweet Grass,
6 Stillwater, Yellowstone, Carbon, and Big Horn;

7 (d) region IV: Lewis and Clark, Powell, Granite, Deer
8 Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park,
9 Gallatin, Madison, and Beaverhead;

10 (e) region V: Lincoln, Flathead, Sanders, Lake,
11 Mineral, Missoula, and Ravalli.

12 (2) (a) A county may, by written request of the board
13 of county commissioners, petition the authority at any time
14 to be removed from a health care planning region and added
15 to another region.

16 (b) The authority shall grant or deny the petition
17 after a public hearing. The authority shall give notice as
18 the authority determines appropriate. The authority shall
19 grant the petition if it appears by a preponderance of the
20 evidence that the petitioning county's health care interests
21 are more strongly associated with the region that the county
22 seeks to join than with the region in which the county is
23 located. If the authority grants the petition, the county is
24 considered for all purposes to be part of the health care
25 planning region as approved by the authority.

1 (3) Within each region, the authority shall establish
2 by rule a regional health care planning board. Each board
3 must include one member from each county within the region.
4 The members on each board shall represent a balance of
5 individuals who are health care consumers and individuals
6 who are recognized for their interest or expertise, or both,
7 in health care. Each regional board should attempt to
8 achieve gender balance.

9 (4) The authority shall, within 30 days of appointment
10 of its members, propose by rule a procedure for selecting
11 members of boards. The authority shall select the members
12 for each board within 180 days of appointment of the
13 authority, using the selection procedure adopted by rule
14 under this subsection. Vacancies on a board must be filled
15 by using the authority's selection process.

16 (5) Regional board members serve 4-year terms, except
17 that of the board members initially selected, at least three
18 members serve for 2 years, at least three members serve for
19 3 years, and at least three members serve for 4 years, to be
20 determined by lot. A majority of each regional board shall
21 select a presiding officer. The presiding officer initially
22 selected must serve a 4-year term. Board members must be
23 compensated and reimbursed in accordance with 2-15-124.

24 **NEW SECTION. Section 18. Powers and duties of boards.**

25 (1) A board shall:

(a) meet at the time and place designated by the presiding officer, but not less than quarterly;

(b) submit an annual budget and grant application to the authority at the time and in the manner directed by the authority;

(c) adopt procedures governing its meetings and other aspects of its day-to-day operations as the board determines necessary;

(d) develop regional health resource plans in the format determined by the authority that must address the health care needs of the region and address the development of health care services in underserved areas of the region and other matters;

(e) revise the regional plan annually;

(f) hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional board;

(g) transmit the regional plan to the authority at the time determined by the authority;

(h) apply to the authority for grant funds for operation of the regional board and account, in the manner specified by the authority, for grant funds provided by the authority; and

(i) seek from ~~local~~ PUBLIC AND PRIVATE sources money to supplement grant funds provided by the authority.

(2) Regional boards may:

(a) recommend that the authority sanction voluntary agreements between health care providers and between health care consumers in the region that will improve the quality of, access to, or affordability of health care but that might constitute a violation of antitrust laws if undertaken without government direction;

(b) make recommendations to the authority regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by health care providers;

(c) undertake voluntary activities to educate consumers, providers, and purchasers and promote voluntary, cooperative community cost containment, access, or quality of care projects; and

(d) make recommendations to the department of health and environmental sciences or to the authority, or both, regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(3) Each regional board may review and advise the authority on regional technical matters relating to the statewide plans required by [section 5], the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and

1 facility contracts with the state, utilization review
2 recommendations, expenditure targets, and uniform health
3 care benefits and the impact of the benefits upon the
4 provision of quality health care within the region.

5 NEW SECTION. **Section 19.** Health care data base --
6 information submitted -- enforcement. (1) The authority
7 shall develop and maintain a unified health care data base
8 that enables the authority, on a statewide basis, to:

9 (a) determine the distribution and capacity of health
10 care resources, including health care facilities, providers,
11 and health care services;

12 (b) identify health care needs and direct statewide and
13 regional health care policy to ensure high-quality and
14 cost-effective health care;

15 (c) conduct evaluations of health care procedures and
16 health care protocols;

17 (d) compare costs of commonly performed health care
18 procedures between providers and health care facilities
19 within a region and make the data readily available to the
20 public; and

21 (e) compare costs of various health care procedures in
22 one location of providers and health care facilities with
23 the costs of the same procedures in other locations of
24 providers and health care facilities.

25 (2) The authority shall by rule require health care

1 providers, health insurers, health care facilities, private
2 entities, and entities of state and local governments to
3 file with the authority the reports, data, schedules,
4 statistics, and other information determined by the
5 authority to be necessary to fulfill the purposes of the
6 data base provided in subsection (1). Material to be filed
7 with the authority may include health insurance claims and
8 enrollment information used by health insurers.

9 (3) The authority may issue subpoenas for the
10 production of information required under this section and
11 may issue subpoenas for and administer oaths to any person.
12 Noncompliance with a subpoena issued by the authority is,
13 upon application by the authority, punishable by a district
14 court as contempt pursuant to Title 3, chapter 1, part 5.

15 (4) The data base must:

16 (a) use unique patient and provider identifiers and a
17 uniform coding system identifying health care services; and

18 (b) reflect all health care utilization, costs, and
19 resources in the state and the health care utilization and
20 costs of services provided to Montana residents in another
21 state.

22 (5) Information in the data base required by law to be
23 kept confidential must be maintained in a manner that does
24 not disclose the identity of the person to whom the
25 information applies. INFORMATION IN THE DATA BASE NOT

REQUIRED BY LAW TO BE KEPT CONFIDENTIAL MUST BE MADE
AVAILABLE BY THE AUTHORITY UPON REQUEST OF ANY PERSON.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

NEW SECTION. Section 20. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

(b) The authority may use plans filed under this section in the development of a unified health care budget.

(2) The plans required by this section must be developed in accordance with standards and procedures established by the authority.

(3) The provisions of this section do not apply to dental insurance.

Section 21. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is hereby-established-as the sole--and--official state agency to administer the state program for comprehensive

health planning and ~~is-hereby-authorized-to~~ shall prepare a plan for comprehensive state health planning. The department ~~authority is-authorized-to~~ may confer and cooperate with ~~any~~ and--all other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department ~~authority~~, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer ~~any-and-all~~ funds which--are now--available-or-which-may-be donated, granted, bequeathed, or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

NEW SECTION. Section 22. Short title. [Sections 22 through 36] may be cited as the "Small Employer Health Insurance Availability Act".

NEW SECTION. Section 23. Purpose. (1) [Sections 22 through 36] must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to purchasers;

(d) to establish rules regarding renewability of coverage;

(e) to establish limitations on the use of preexisting condition exclusions;

(f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;

(g) to provide for the establishment of a reinsurance program; and

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) [Sections 22 through 36] are not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

NEW SECTION. Section 24. Definitions. As used in [sections 22 through 36], the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of [section 27], based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier

in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "ASSESSABLE CARRIER" MEANS ALL INDIVIDUAL CARRIERS OF DISABILITY INSURANCE AND ALL CARRIERS OF GROUP DISABILITY INSURANCE, EXCLUDING THE STATE GROUP BENEFITS PLAN PROVIDED FOR IN TITLE 2, CHAPTER 18, PART 8, THE MONTANA UNIVERSITY SYSTEM HEALTH PLAN, AND ANY SELF-FUNDED DISABILITY INSURANCE PLAN PROVIDED BY A POLITICAL SUBDIVISION OF THE STATE.

~~(3)~~(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

~~(4)~~(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to [section 31].

~~(5)~~(6) "Board" means the board of directors of the program established pursuant to [section 30].

~~(6)~~(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an

insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of [sections 22 through 36], companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

~~(7)~~(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claims experience, health status, and duration of coverage are not case characteristics for purposes of [sections 22 through 36].

~~(8)~~(9) "Class of business" means all or a separate grouping of small employers established pursuant to [section 26].

~~(9)~~(10) "Committee" means the health benefit plan committee created pursuant to [section 31].

~~(10)~~(11) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined to be a dependent in the health benefit plan covering the employee.

~~(11)~~(12) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

~~(12)~~(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based

on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

~~(13)~~(14) "Health benefit plan" means any hospital or medical policy or certificate PROVIDING FOR PHYSICAL AND MENTAL HEALTH CARE issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

~~(14)~~(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

~~(15)~~(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial

enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

~~(16)~~(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers

with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

~~(17)~~(18) "Plan of operation" means the operation of the program established pursuant to [section 30].

~~(18)~~(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~(19)~~(20) "Program" means the Montana small employer health reinsurance program created by [section 30].

~~(20)~~(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

~~(21)~~(22) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(22)~~(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to [section 30].

~~(23)~~(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

~~(24)~~(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that ARE CONSIDERED ONE EMPLOYER IF THEY:

(A) are affiliated companies ~~or that;~~

(B) are eligible to file a combined tax return for purposes of state taxation; OR

(C) THAT ARE MEMBERS OF AN ASSOCIATION THAT:

(I) HAS BEEN IN EXISTENCE FOR 1 YEAR PRIOR TO [THE EFFECTIVE DATE OF SECTIONS 22 THROUGH 36];

(II) AND---THAT PROVIDES A HEALTH BENEFIT PLAN TO EMPLOYEES OF ITS MEMBERS AS A GROUP are--considered--one employer; AND

(III) DOES NOT DENY COVERAGE TO ANY MEMBER OF ITS ASSOCIATION OR ANY EMPLOYEE OF ITS MEMBERS WHO APPLIES FOR COVERAGE AS PART OF A GROUP.

†25†(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

†26†(27) "Standard health benefit plan" means a health benefit plan developed pursuant to [section 31].

NEW SECTION. Section 25. Applicability and scope. [Sections 22 through 35] apply to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

NEW SECTION. Section 26. Establishment of classes of business. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner may SHALL adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of

additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. **Section 27.** Restrictions relating to premium rates. (1) Premium rates for health benefit plans under [sections 22 through 36] are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate; or

(ii) if the Montana health care authority established by [section 3] certifies to the commissioner that the cost containment goal set forth in [section 7] is met on or before January 1, 1999, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage may not vary from the index by more than 20% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period--~~in~~; IN the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health

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status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

~~{f}--Premium-rates-for-health-benefit-plans-must--comply with--the--requirements-of-this-section,--notwithstanding-any assessments-paid--or--payable--by--small--employer--carriers pursuant-to-{section-38}--~~

~~{f}(E)~~ If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

~~{g}(F)~~ In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; ~~in; IN~~ the case of a health benefit plan into which the small employer

carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; AND

(ii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

~~{h}(G)~~ A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

~~{i}(H)~~ For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

~~{j}--The--small--employer--carrier--may--not--use---case characteristics,--other--than--age,--without--prior--approval--of the--commissioner.~~

{k}{I} The commissioner may SHALL adopt rules to implement the provisions of this section and to ensure that rating practices used by small employer carriers are consistent with the purposes of [sections 22 through 36], including rules that ensure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences because of the nature of the groups.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer

carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting

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practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with [sections 22 through 36] and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of [sections 22 through 36] and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

NEW SECTION. Section 28. Renewability of coverage. (1)

A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible

employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the

1 affected small employers.

2 (g) the commissioner finds that the continuation of the
3 coverage would:

4 (i) not be in the best interests of the policyholders
5 or certificate holders; or

6 (ii) impair the carrier's ability to meet its
7 contractual obligations.

8 (2) If the commissioner makes a finding under
9 subsection (1)(g), the commissioner shall assist affected
10 small employers in finding replacement coverage.

11 (3) A small employer carrier that elects not to renew a
12 health benefit plan under subsection (1)(f) is prohibited
13 from writing new business in the small employer market in
14 this state for a period of 5 years from the date of notice
15 to the commissioner.

16 (4) In the case of a small employer carrier doing
17 business in one established geographic service area of the
18 state, the rules set forth in this section apply only to the
19 carrier's operations in that service area.

20 NEW SECTION. Section 29. Availability of coverage --
21 required plans. (1) (a) As a condition of transacting
22 business in this state with small employers, each small
23 employer carrier shall offer to small employers at least two
24 health benefit plans. One plan must be a basic health
25 benefit plan, and one plan must be a standard health benefit

1 plan.

2 (b) (i) A small employer carrier shall issue a basic
3 health benefit plan or a standard health benefit plan to any
4 eligible small employer that applies for either plan and
5 agrees to make the required premium payments and to satisfy
6 the other reasonable provisions of the health benefit plan
7 not inconsistent with [sections 22 through 36].

8 (ii) In the case of a small employer carrier that
9 establishes more than one class of business pursuant to
10 [section 26], the small employer carrier shall maintain and
11 offer to eligible small employers at least one basic health
12 benefit plan and at least one standard health benefit plan
13 in each established class of business. A small employer
14 carrier may apply reasonable criteria in determining whether
15 to accept a small employer into a class of business,
16 provided that:

17 (A) the criteria are not intended to discourage or
18 prevent acceptance of small employers applying for a basic
19 or standard health benefit plan;

20 (B) the criteria are not related to the health status
21 or claims experience of the small employers' employees;

22 (C) the criteria are applied consistently to all small
23 employers that apply for coverage in that class of business;
24 and

25 (D) the small employer carrier provides for the

1 acceptance of all eligible small employers into one or more
2 classes of business.

3 (iii) The provisions of subsection (1)(b)(ii) may not be
4 applied to a class of business into which the small employer
5 carrier is no longer enrolling new small businesses.

6 (c) The provisions of this section are effective 180
7 days after the commissioner's approval of the basic health
8 benefit plan and the standard health benefit plan developed
9 pursuant to [section 31], provided that if the program
10 created pursuant to [section 30] is not yet operative on
11 that date, the provisions of this section are effective on
12 the date that the program begins operation.

13 (2) (a) A small employer carrier shall, pursuant to
14 33-1-501, file the basic health benefit plans and the
15 standard health benefit plans to be used by the small
16 employer carrier.

17 (b) The commissioner may at any time, after providing
18 notice and an opportunity for a hearing to the small
19 employer carrier, disapprove the continued use by a small
20 employer carrier of a basic or standard health benefit plan
21 on the grounds that the plan does not meet the requirements
22 of [sections 22 through 36].

23 (3) Health benefit plans covering small employers must
24 comply with the following provisions:

25 (a) A health benefit plan may not, because of a

1 preexisting condition, deny, exclude, or limit benefits for
2 a covered individual for losses incurred more than 12 months
3 following the effective date of the individual's coverage. A
4 health benefit plan may not define a preexisting condition
5 more restrictively than 33-22-216, except that the condition
6 may be excluded for a maximum of 12 months.

7 (b) A health benefit plan must waive any time period
8 applicable to a preexisting condition exclusion or
9 limitation period with respect to particular services for
10 the period of time an individual was previously covered by
11 qualifying previous coverage that provided benefits with
12 respect to those services if the qualifying previous
13 coverage was continuous to a date not less than 30 days
14 prior to the submission of an application for new coverage.
15 This subsection (3)(b) does not preclude application of any
16 waiting period applicable to all new enrollees under the
17 health benefit plan.

18 (c) A health benefit plan may exclude coverage for late
19 enrollees for 18 months or for an 18-month preexisting
20 condition exclusion, provided that if both a period of
21 exclusion from coverage and a preexisting condition
22 exclusion are applicable to a late enrollee, the combined
23 period may not exceed 18 months from the date the individual
24 enrolls for coverage under the health benefit plan.

25 (d) (i) Requirements used by a small employer carrier

in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to

offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

NEW SECTION. **Section 30.** Small employer carrier reinsurance program -- board membership -- plan of operation -- criteria -- exemption from taxation. (1) There is a nonprofit entity to be known as the Montana small employer

1 health reinsurance program.

2 (2) (a) The program must operate subject to the
3 supervision and control of the board. The board consists of
4 nine members appointed by the commissioner plus the
5 commissioner or the commissioner's designated
6 representative, who shall serve as an ex officio member of
7 the board.

8 (b) (i) In selecting the members of the board, the
9 commissioner shall include representatives of small
10 employers, small employer carriers, and other qualified
11 individuals, as determined by the commissioner. At least six
12 of the members of the board must be representatives of small
13 employer carriers, one from each of the five small employer
14 carriers with the highest annual premium volume derived from
15 health benefit plans issued to small employers in Montana in
16 the previous calendar year and one from the remaining small
17 employer carriers. One member of the board must be a person
18 licensed, certified, or otherwise authorized by the laws of
19 Montana to provide health care in the ordinary course of
20 business or in the practice of a profession. One member of
21 the board must be a small employer who is not active in the
22 health care or insurance fields. One member of the board
23 must be a representative of the general public who is
24 employed by a small employer and is not employed in the
25 health care or insurance fields.

1 (ii) The initial board members' terms are as follows:
2 one-third of the members shall serve a term of 1 year;
3 one-third of the members shall serve a term of 2 years; and
4 one-third of the members shall serve a term of 3 years.
5 Subsequent board members shall serve for a term of 3 years.
6 A board member's term continues until that member's
7 successor is appointed.

8 (iii) A vacancy on the board must be filled by the
9 commissioner. The commissioner may remove a board member for
10 cause.

11 (3) Within [60 days of the effective date of this
12 section] AND ON OR BEFORE MARCH 1 OF EACH YEAR AFTER THAT
13 DATE, each ~~small-employer~~ ASSESSABLE carrier shall file with
14 the commissioner the carrier's net health insurance premium
15 derived from health benefit plans issued ~~to-small-employers~~
16 in this state in the previous calendar year.

17 (4) Within 180 days after the appointment of the
18 initial board, the board shall submit to the commissioner a
19 plan of operation and may at any time submit amendments to
20 the plan necessary or suitable to ensure the fair,
21 reasonable, and equitable administration of the program. The
22 commissioner may, after notice and hearing, approve the plan
23 of operation if the commissioner determines it to be
24 suitable to ensure the fair, reasonable, and equitable
25 administration of the program and if the plan of operation

provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(5) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(6) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from reinsuring ASSESSABLE carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(E) ESTABLISH PROCEDURES FOR ALLOCATING A PORTION OF

PREMIUMS COLLECTED FROM REINSURING CARRIERS TO FUND
ADMINISTRATIVE EXPENSES INCURRED OR TO BE INCURRED BY THE
PROGRAM; AND

(F) provide for any additional matters necessary for the implementation and administration of the program.

(7) The program ~~must--have~~ HAS the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program ~~must-have-the-specific-authority-to~~ MAY:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of [sections 22 through 36], including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any assessments PREMIUMS and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which

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reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of [sections 22 through 36];

(e) establish rules, conditions, and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program; and

(H) TO THE EXTENT PERMITTED BY FEDERAL LAW AND IN ACCORDANCE WITH SUBSECTION (11)(C), MAKE ANNUAL FISCAL YEAREND ASSESSMENTS AGAINST ASSESSABLE CARRIERS AND MAKE INTERIM ASSESSMENTS TO FUND CLAIMS INCURRED BY THE PROGRAM; AND

~~(h)~~ (I) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection (8):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the

level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to

1 reflect increases in costs and utilization within the
 2 standard market for health benefit plans within the state.
 3 The adjustment may not be less than the annual change in the
 4 medical component of the consumer price index for all urban
 5 consumers of the United States department of labor, bureau
 6 of labor statistics, unless the board proposes and the
 7 commissioner approves a lower adjustment factor.

8 (e) A small employer carrier may terminate reinsurance
 9 with the program for one or more of the reinsured employees
 10 or dependents of a small employer on any anniversary of the
 11 health benefit plan.

12 (f) A small employer group business HEALTH BENEFIT PLAN
 13 in effect before January 1, 1994, may not be reinsured by
 14 the program until January 1, 1997, and then only if the
 15 board determines that sufficient funding sources are
 16 available.

17 (g) A reinsuring carrier shall apply all managed care
 18 and claims-handling techniques, including utilization
 19 review, individual case management, preferred provider
 20 provisions, and other managed care provisions or methods of
 21 operation consistently with respect to reinsured and
 22 nonreinsured business.

23 (9) (a) As part of the plan of operation, the board
 24 shall establish a methodology for determining premium rates
 25 to be charged by the program for reinsuring small employers

1 and individuals pursuant to this section. The methodology
 2 must include a system for classification of small employers
 3 that reflects the types of case characteristics commonly
 4 used by small employer carriers in the state. The
 5 methodology must provide for the development of base
 6 reinsurance premium rates that must be multiplied by the
 7 factors set forth in subsection (9)(b) to determine the
 8 premium rates for the program. The base reinsurance premium
 9 rates must be established by the board, subject to the
 10 approval of the commissioner, and must be set at levels that
 11 reasonably approximate gross premiums charged to small
 12 employers by small employer carriers for health benefit
 13 plans with benefits similar to the standard health benefit
 14 plan, adjusted to reflect retention levels required under
 15 [sections 22 through 36].

16 (b) Premiums for the program are as follows:

17 (i) An entire small employer group may be reinsured for
 18 a rate that is one and one-half times the base reinsurance
 19 premium rate for the group established pursuant to this
 20 subsection (9).

21 (ii) An eligible employee or dependent may be reinsured
 22 for a rate that is five times the base reinsurance premium
 23 rate for the individual established pursuant to this
 24 subsection (9).

25 (c) The board periodically shall review the methodology

1 established under subsection (9)(a), including the system of
 2 classification and any rating factors, to ensure that it
 3 reasonably reflects the claims experience of the program.
 4 The board may propose changes to the methodology that are
 5 subject to the approval of the commissioner.

6 (d) The board may consider adjustments to the premium
 7 rates charged by the program to reflect the use of effective
 8 cost containment and managed care arrangements.

9 (10) If a health benefit plan for a small employer is
 10 entirely or partially reinsured with the program, the
 11 premium charged to the small employer for any rating period
 12 for the coverage issued must meet the requirements relating
 13 to premium rates set forth in [section 27].

14 (11) (a) Prior to March 1 of each year, the board shall
 15 determine and report to the commissioner the program net
 16 loss for the previous calendar year, including
 17 administrative expenses and incurred losses for the year,
 18 taking into account investment income and other appropriate
 19 gains and losses.

20 (b) ~~A-net-loss-for-the-year-must-be-reimbursed-by-the~~
 21 ~~commissioner--from--funds-specifically-appropriated-for-that~~
 22 ~~purpose-~~ TO THE EXTENT PERMITTED BY FEDERAL LAW, EACH
 23 ASSESSABLE CARRIER SHALL SHARE IN ANY NET LOSS OF THE
 24 PROGRAM FOR THE YEAR IN AN AMOUNT EQUAL TO THE RATIO OF THE
 25 TOTAL PREMIUMS EARNED IN THE PREVIOUS CALENDAR YEAR FROM

1 HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY BY
 2 EACH ASSESSABLE CARRIER DIVIDED BY THE TOTAL PREMIUMS EARNED
 3 IN THE PREVIOUS CALENDAR YEAR FROM HEALTH BENEFIT PLANS
 4 DELIVERED OR ISSUED FOR DELIVERY BY ALL ASSESSABLE CARRIERS
 5 IN THE STATE.

6 (C) THE BOARD SHALL MAKE AN ANNUAL DETERMINATION IN
 7 ACCORDANCE WITH THIS SECTION OF EACH ASSESSABLE CARRIER'S
 8 LIABILITY FOR ITS SHARE OF THE NET LOSS OF THE PROGRAM AND,
 9 EXCEPT AS OTHERWISE PROVIDED BY THIS SECTION, MAKE AN ANNUAL
 10 FISCAL YEAREND ASSESSMENT AGAINST EACH ASSESSABLE CARRIER TO
 11 THE EXTENT OF THAT LIABILITY. IF APPROVED BY THE
 12 COMMISSIONER, THE BOARD MAY ALSO MAKE INTERIM ASSESSMENTS
 13 AGAINST ASSESSABLE CARRIERS TO FUND CLAIMS INCURRED BY THE
 14 PROGRAM. ANY INTERIM ASSESSMENT MUST BE CREDITED AGAINST THE
 15 AMOUNT OF ANY FISCAL YEAREND ASSESSMENT DUE OR TO BE DUE
 16 FROM AN ASSESSABLE CARRIER. PAYMENT OF A FISCAL YEAREND OR
 17 INTERIM ASSESSMENT IS DUE WITHIN 30 DAYS OF RECEIPT BY THE
 18 ASSESSABLE CARRIER OF WRITTEN NOTICE OF THE ASSESSMENT. AN
 19 ASSESSABLE CARRIER THAT CEASES DOING BUSINESS WITHIN THE
 20 STATE IS LIABLE FOR ASSESSMENTS UNTIL THE END OF THE
 21 CALENDAR YEAR IN WHICH THE ASSESSABLE CARRIER CEASED DOING
 22 BUSINESS. THE BOARD MAY DETERMINE NOT TO ASSESS AN
 23 ASSESSABLE CARRIER IF THE ASSESSABLE CARRIER'S LIABILITY
 24 DETERMINED IN ACCORDANCE WITH THIS SECTION DOES NOT EXCEED
 25 \$10.

1 (12) The participation in the program as reinsuring
 2 carriers; the establishment of rates, forms, or procedures;
 3 or any other joint collective action required by [sections
 4 22 through 36] may not be the basis of any legal action,
 5 criminal or civil liability, or penalty against the program
 6 or any of its reinsuring carriers, either jointly or
 7 separately.

8 (13) The board, as part of the plan of operation, shall
 9 develop standards setting forth the minimum levels of
 10 compensation to be paid to producers for the sale of basic
 11 and standard health benefit plans. In establishing the
 12 standards, the board shall take into consideration the need
 13 to ensure the broad availability of coverages, the
 14 objectives of the program, the time and effort expended in
 15 placing the coverage, the need to provide ongoing service to
 16 small employers, the levels of compensation currently used
 17 in the industry, and the overall costs of coverage to small
 18 employers selecting these plans.

19 (14) The program is exempt from taxation.

20 (15) ON OR BEFORE MARCH 1 OF EACH YEAR, THE COMMISSIONER
 21 SHALL EVALUATE THE OPERATION OF THE PROGRAM AND REPORT TO
 22 THE GOVERNOR AND THE LEGISLATURE IN WRITING THE RESULTS OF
 23 THE EVALUATION. THE REPORT MUST INCLUDE AN ESTIMATE OF
 24 FUTURE COSTS OF THE PROGRAM, ASSESSMENTS NECESSARY TO PAY
 25 THOSE COSTS, THE APPROPRIATENESS OF PREMIUMS CHARGED BY THE

1 PROGRAM, THE LEVEL OF INSURANCE RETENTION UNDER THE PROGRAM,
 2 THE COST OF COVERAGE OF SMALL EMPLOYERS, AND ANY
 3 RECOMMENDATIONS FOR CHANGE TO THE PLAN OF OPERATION.

4 NEW SECTION. Section 31. Health benefit plan committee
 5 -- recommendations. (1) The commissioner shall appoint a
 6 health benefit plan committee. The committee is composed of
 7 representatives-of-carriers,-small-employers-and--employees,
 8 health-care-providers,-and-producers. THE FOLLOWING MEMBERS:

9 (A) ONE HEALTH CARE PROVIDER;

10 (B) ONE REPRESENTATIVE OF THE HEALTH INSURANCE
 11 INDUSTRY;

12 (C) ONE EMPLOYEE OF A SMALL EMPLOYER;

13 (D) ONE MEMBER OF A LABOR UNION; AND

14 (E) ONE REPRESENTATIVE OF THE GENERAL PUBLIC WHO MAY
 15 NOT REPRESENT THE PERSONS OR GROUPS LISTED IN SUBSECTIONS
 16 (1)(A) THROUGH (1)(D).

17 (2) The committee shall, AFTER HOLDING A PUBLIC
 18 HEARING, recommend the form and level of coverages to be
 19 made by small employer carriers pursuant to [section 29].

20 (3) (a) The committee shall recommend benefit levels,
 21 cost-sharing levels, exclusions, and limitations for the
 22 basic health benefit plan and the standard health benefit
 23 plan. The committee shall design a basic health benefit plan
 24 and a standard health benefit plan that contain benefit and
 25 cost-sharing levels that are consistent with the basic

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1 method of operation and the benefit plans of health
2 maintenance organizations, including any restrictions
3 imposed by federal law.

4 (b) The plans recommended by the committee must include
5 cost containment features, such as:

6 (i) utilization review of health care services,
7 including review of the medical necessity of hospital and
8 physician services;

9 (ii) case management;

10 (iii) selective contracting with hospitals, physicians,
11 and other health care providers;

12 (iv) reasonable benefit differentials applicable to
13 providers that participate or do not participate in
14 arrangements using restricted network provisions; and

15 (v) other managed care provisions.

16 (c) The committee shall submit the health benefit plans
17 described in subsections (3)(a) and (3)(b) to the
18 commissioner ~~for---approval~~ within 180 days after the
19 appointment of the committee. THE COMMISSIONER SHALL ADOPT
20 AS A RULE PURSUANT TO TITLE 2, CHAPTER 4, PART 3, THE HEALTH
21 BENEFIT PLANS REQUIRED BY [SECTION 29(1)] TO BE OFFERED IN
22 THIS STATE.

23 NEW SECTION. Section 32. Periodic market evaluation --
24 report. The board, in consultation with members of the
25 committee, shall study and report at least every 3 years to

1 the commissioner on the effectiveness of [sections 22
2 through 36]. The report must analyze the effectiveness of
3 [sections 22 through 36] in promoting rate stability,
4 product availability, and coverage affordability. The report
5 may contain recommendations for actions to improve the
6 overall effectiveness, efficiency, and fairness of the small
7 employer health insurance markets. The report must address
8 whether carriers and producers are fairly and actively
9 marketing or issuing health benefit plans to small employers
10 in fulfillment of the purposes of [sections 22 through 36].
11 The report may contain recommendations for market conduct or
12 other regulatory standards or action.

13 NEW SECTION. Section 33. Waiver of certain laws. A law
14 that requires the inclusion of a specific category of
15 licensed health care practitioner--does PRACTITIONERS AND A
16 LAW THAT REQUIRES THE COVERAGE OF A HEALTH CARE SERVICE OR
17 BENEFIT DO not apply to a basic health benefit plan
18 delivered or issued for delivery to small employers in this
19 state pursuant to [sections 22 through 36] BUT DO APPLY TO A
20 STANDARD HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR
21 DELIVERY TO SMALL EMPLOYERS IN THIS STATE PURSUANT TO
22 [SECTIONS 22 THROUGH 36].

23 NEW SECTION. Section 34. Administrative procedure. The
24 commissioner shall adopt rules in accordance with the
25 Montana Administrative Procedure Act to implement and

1 administer [sections 22 through 36].

2 NEW SECTION. **Section 35.** Standards to ensure fair
3 marketing. (1) Each small employer carrier shall actively
4 market health benefit plan coverage, including the basic and
5 standard health benefit plans, to eligible small employers
6 in the state. If a small employer carrier denies coverage
7 other than the basic or standard health benefit plans to a
8 small employer on the basis of claims experience of the
9 small employer or the health status or claims experience of
10 its employees or dependents, the small employer carrier
11 shall offer the small employer the opportunity to purchase a
12 basic health benefit plan or a standard health benefit plan.

13 (2) (a) Except as provided in subsection (2)(b), a
14 small employer carrier or producer may not directly or
15 indirectly engage in the following activities:

16 (i) encouraging or directing small employers to refrain
17 from filing an application for coverage with the small
18 employer carrier because of the health status of the
19 employer's employees or the claims experience, industry,
20 occupation, or geographic location of the small employer;

21 (ii) encouraging or directing small employers to seek
22 coverage from another carrier because of the health status
23 of the employer's employees or the claims experience,
24 industry, occupation, or geographic location of the small
25 employer.

1 (b) The provisions of subsection (2)(a) do not apply
2 with respect to information provided by a small employer
3 carrier or producer to a small employer regarding the
4 established geographic service area or a restricted network
5 provision of a small employer carrier.

6 (3) (a) Except as provided in subsection (3)(b), a
7 small employer carrier may not, directly or indirectly,
8 enter into any contract, agreement, or arrangement with a
9 producer that provides for or results in the compensation
10 paid to a producer for the sale of a health benefit plan to
11 be varied because of the health status of the employer's
12 employees or the claims experience, industry, occupation, or
13 geographic location of the small employer.

14 (b) Subsection (3)(a) does not apply with respect to a
15 compensation arrangement that provides compensation to a
16 producer on the basis of the percentage of a premium,
17 provided that the percentage may not vary because of the
18 health status of the employer's employees or the claims
19 experience, industry, occupation, or geographic area of the
20 small employer.

21 (4) A small employer carrier shall provide reasonable
22 compensation, as provided under the plan of operation of the
23 program, to a producer, if any, for the sale of a basic or
24 standard health benefit plan.

25 (5) A small employer carrier may not terminate, fail to

1 renew, or limit its contract or agreement of representation
 2 with a producer for any reason related to the health status
 3 of the employer's employees or the claims experience,
 4 industry, occupation, or geographic location of the small
 5 employers placed by the producer with the small employer
 6 carrier.

7 (6) A small employer carrier or producer may not induce
 8 or otherwise encourage a small employer to separate or
 9 otherwise exclude an employee from health coverage or
 10 benefits provided in connection with the employee's
 11 employment.

12 (7) Denial by a small employer carrier of an
 13 application for coverage from a small employer must be in
 14 writing and must state the reason or reasons for the denial.

15 (8) The commissioner may adopt rules setting forth
 16 additional standards to provide for the fair marketing and
 17 broad availability of health benefit plans to small
 18 employers in this state.

19 (9) (a) A violation of this section by a small employer
 20 carrier or a producer is an unfair trade practice under
 21 33-18-102.

22 (b) If a small employer carrier enters into a contract,
 23 agreement, or other arrangement with an administrator who
 24 holds a certificate of registration pursuant to 33-17-603 to
 25 provide administrative, marketing, or other services related

1 to the offering of health benefit plans to small employers
 2 in this state, the administrator is subject to this section
 3 as if the administrator were a small employer carrier.

4 NEW SECTION. Section 36. Restoration of terminated
 5 coverage. The commissioner may promulgate rules to require
 6 small employer carriers, as a condition of transacting
 7 business with small employers in this state after [the
 8 effective date of this section], to reissue a health benefit
 9 plan to any small employer whose health benefit plan has
 10 been terminated or not renewed by the carrier after [6
 11 months prior to the effective date of this section]. The
 12 commissioner may prescribe the terms for the reissuance of
 13 coverage that the commissioner finds are reasonable and
 14 necessary to provide continuity of coverage to small
 15 employers.

16 NEW SECTION. SECTION 37. FINDING AND PURPOSE. THE
 17 LEGISLATURE FINDS THAT THE GOALS OF CONTROLLING HEALTH CARE
 18 COSTS AND IMPROVING THE QUALITY OF AND ACCESS TO HEALTH CARE
 19 WILL BE SIGNIFICANTLY ENHANCED IN SOME CASES BY COOPERATIVE
 20 AGREEMENTS AMONG HEALTH CARE FACILITIES. THE PURPOSE OF
 21 [SECTIONS 37 THROUGH 44] IS TO PROVIDE THE STATE, THROUGH
 22 THE AUTHORITY, WITH DIRECT SUPERVISION AND CONTROL OVER THE
 23 IMPLEMENTATION OF COOPERATIVE AGREEMENTS AMONG HEALTH CARE
 24 FACILITIES FOR WHICH CERTIFICATES OF PUBLIC ADVANTAGE ARE
 25 GRANTED. IT IS THE INTENT OF THE LEGISLATURE THAT

SUPERVISION AND CONTROL OVER THE IMPLEMENTATION OF THESE AGREEMENTS SUBSTITUTE STATE REGULATION OF FACILITIES FOR COMPETITION BETWEEN FACILITIES AND THAT THIS REGULATION HAVE THE EFFECT OF GRANTING THE PARTIES TO THE AGREEMENTS STATE ACTION IMMUNITY FOR ACTIONS THAT MIGHT OTHERWISE BE CONSIDERED TO BE IN VIOLATION OF STATE OR FEDERAL, OR BOTH, ANTITRUST LAWS.

NEW SECTION. SECTION 38. COOPERATIVE AGREEMENTS ALLOWED. A HEALTH CARE FACILITY MAY ENTER INTO A COOPERATIVE AGREEMENT WITH ONE OR MORE HEALTH CARE FACILITIES.

NEW SECTION. SECTION 39. CERTIFICATE OF PUBLIC ADVANTAGE -- STANDARDS FOR CERTIFICATION -- TIME FOR ACTION BY AUTHORITY. (1) PARTIES TO A COOPERATIVE AGREEMENT MAY APPLY TO THE AUTHORITY FOR A CERTIFICATE OF PUBLIC ADVANTAGE. THE APPLICATION FOR A CERTIFICATE MUST INCLUDE A COPY OF THE PROPOSED OR EXECUTED AGREEMENT, A DESCRIPTION OF THE SCOPE OF THE COOPERATION CONTEMPLATED BY THE AGREEMENT, AND THE AMOUNT, NATURE, SOURCE, AND RECIPIENT OF ANY CONSIDERATION PASSING TO ANY PERSON UNDER THE TERMS OF THE AGREEMENT.

(2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE APPLICATION FOR A CERTIFICATE BEFORE ACTING UPON THE APPLICATION. THE AUTHORITY MAY NOT ISSUE A CERTIFICATE UNLESS THE AUTHORITY FINDS THAT THE AGREEMENT IS LIKELY TO RESULT IN LOWER HEALTH CARE COSTS OR IN GREATER ACCESS TO OR

QUALITY OF HEALTH CARE THAN WOULD OCCUR WITHOUT THE AGREEMENT. IF THE AUTHORITY DENIES AN APPLICATION FOR A CERTIFICATE FOR AN EXECUTED AGREEMENT, THE AGREEMENT IS VOID UPON THE DECISION OF THE AUTHORITY NOT TO ISSUE THE CERTIFICATE. PARTIES TO A VOID AGREEMENT MAY NOT IMPLEMENT OR CARRY OUT THE AGREEMENT.

(3) THE AUTHORITY SHALL DENY THE APPLICATION FOR A CERTIFICATE OR ISSUE A CERTIFICATE WITHIN 90 DAYS OF RECEIPT OF A COMPLETED APPLICATION.

NEW SECTION. SECTION 40. RECONSIDERATION BY AUTHORITY.

(1) IF THE AUTHORITY DENIES AN APPLICATION AND REFUSES TO ISSUE A CERTIFICATE, A PARTY TO THE AGREEMENT MAY REQUEST THAT THE AUTHORITY RECONSIDER ITS DECISION. THE AUTHORITY SHALL RECONSIDER ITS DECISION IF THE PARTY APPLYING FOR RECONSIDERATION SUBMITS THE REQUEST TO THE AUTHORITY IN WRITING WITHIN 30 CALENDAR DAYS OF THE AUTHORITY'S DECISION TO DENY THE INITIAL APPLICATION.

(2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE APPLICATION FOR RECONSIDERATION. THE HEARING MUST BE HELD WITHIN 30 DAYS OF RECEIPT OF THE REQUEST FOR RECONSIDERATION UNLESS THE PARTY APPLYING FOR RECONSIDERATION AGREES TO A HEARING AT A LATER TIME. THE HEARING MUST BE HELD PURSUANT TO 2-4-604.

(3) THE AUTHORITY SHALL MAKE A DECISION TO DENY THE APPLICATION OR TO ISSUE THE CERTIFICATE WITHIN 30 DAYS OF

1 THE CONCLUSION OF THE HEARING REQUIRED BY SUBSECTION (2).
 2 THE DECISION OF THE AUTHORITY MUST BE PART OF WRITTEN
 3 FINDINGS OF FACT AND CONCLUSIONS OF LAW SUPPORTING THE
 4 DECISION. THE FINDINGS, CONCLUSIONS, AND DECISION MUST BE
 5 SERVED UPON THE APPLICANT FOR RECONSIDERATION.

6 NEW SECTION. SECTION 41. REVOCATION OF CERTIFICATE BY
 7 AUTHORITY. (1) THE AUTHORITY SHALL REVOKE A CERTIFICATE
 8 PREVIOUSLY GRANTED BY IT IF THE AUTHORITY DETERMINES THAT
 9 THE COOPERATIVE AGREEMENT IS NOT RESULTING IN LOWER HEALTH
 10 CARE COSTS OR GREATER ACCESS TO OR QUALITY OF HEALTH CARE
 11 THAN WOULD OCCUR IN ABSENCE OF THE AGREEMENT.

12 (2) A CERTIFICATE MAY NOT BE REVOKED BY THE AUTHORITY
 13 WITHOUT GIVING NOTICE AND AN OPPORTUNITY FOR A HEARING
 14 BEFORE THE AUTHORITY AS FOLLOWS:

15 (A) WRITTEN NOTICE OF THE PROPOSED REVOCATION MUST BE
 16 GIVEN TO THE PARTIES TO THE AGREEMENT FOR WHICH THE
 17 CERTIFICATE WAS ISSUED AT LEAST 120 DAYS BEFORE THE
 18 EFFECTIVE DATE OF THE PROPOSED REVOCATION.

19 (B) A HEARING MUST BE PROVIDED PRIOR TO REVOCATION IF A
 20 PARTY TO THE AGREEMENT SUBMITS A WRITTEN REQUEST FOR A
 21 HEARING TO THE AUTHORITY WITHIN 30 CALENDAR DAYS AFTER
 22 NOTICE IS MAILED TO THE PARTY UNDER SUBSECTION (2)(A).

23 (C) WITHIN 30 CALENDAR DAYS OF RECEIPT OF THE REQUEST
 24 FOR A HEARING, THE AUTHORITY SHALL HOLD A PUBLIC HEARING TO
 25 DETERMINE WHETHER OR NOT TO REVOKE THE CERTIFICATE. THE

1 HEARING MUST BE HELD IN ACCORDANCE WITH 2-4-604.

2 (3) THE AUTHORITY SHALL MAKE ITS FINAL DECISION AND
 3 SERVE THE PARTIES WITH WRITTEN FINDINGS OF FACT AND
 4 CONCLUSIONS OF LAW IN SUPPORT OF ITS DECISION WITHIN 30 DAYS
 5 AFTER THE CONCLUSION OF THE HEARING OR, IF NO HEARING IS
 6 REQUESTED, WITHIN 30 DAYS OF THE DATE OF EXPIRATION OF THE
 7 TIME TO REQUEST A HEARING.

8 (4) IF A CERTIFICATE OF PUBLIC ADVANTAGE IS REVOKED BY
 9 THE AUTHORITY, THE AGREEMENT FOR WHICH THE CERTIFICATE WAS
 10 ISSUED IS TERMINATED.

11 NEW SECTION. SECTION 42. APPEAL. A PARTY TO A
 12 COOPERATIVE AGREEMENT MAY APPEAL, IN THE MANNER PROVIDED IN
 13 TITLE 2, CHAPTER 4, PART 7, A FINAL DECISION BY THE
 14 AUTHORITY TO DENY AN APPLICATION FOR A CERTIFICATE OR A
 15 DECISION BY THE AUTHORITY TO REVOKE A CERTIFICATE. A
 16 REVOCATION OF A CERTIFICATE PURSUANT TO [SECTION 41] DOES
 17 NOT BECOME FINAL UNTIL THE TIME FOR APPEAL HAS EXPIRED. IF A
 18 DECISION TO REVOKE A CERTIFICATE IS APPEALED, THE DECISION
 19 IS STAYED PENDING RESOLUTION OF THE APPEAL BY THE COURTS.

20 NEW SECTION. SECTION 43. RECORD OF AGREEMENTS TO BE
 21 KEPT. THE AUTHORITY SHALL KEEP A COPY OF COOPERATIVE
 22 AGREEMENTS FOR WHICH A CERTIFICATE IS IN EFFECT PURSUANT TO
 23 [SECTIONS 37 THROUGH 44]. A PARTY TO A COOPERATIVE AGREEMENT
 24 WHO TERMINATES THE AGREEMENT SHALL NOTIFY THE AUTHORITY IN
 25 WRITING OF THE TERMINATION WITHIN 30 DAYS AFTER THE

1 TERMINATION.

2 NEW SECTION. SECTION 44. RULEMAKING. THE AUTHORITY
 3 SHALL ADOPT RULES TO IMPLEMENT [SECTIONS 37 THROUGH 43]. THE
 4 RULES SHALL INCLUDE RULES:

5 (1) SPECIFYING THE FORM AND CONTENT OF APPLICATIONS FOR
 6 A CERTIFICATE;

7 (2) SPECIFYING NECESSARY DETAILS FOR RECONSIDERATION OF
 8 DENIAL OF CERTIFICATES, REVOCATIONS OF CERTIFICATES,
 9 HEARINGS REQUIRED OR AUTHORIZED BY [SECTIONS 37 THROUGH 43],
 10 AND APPEALS; AND

11 (3) TO EFFECT THE ACTIVE SUPERVISION BY THE AUTHORITY
 12 OF AGREEMENTS BETWEEN HEALTH CARE FACILITIES. THESE RULES
 13 MAY INCLUDE REPORTING REQUIREMENTS FOR PARTIES TO AN
 14 AGREEMENT FOR WHICH A CERTIFICATE IS IN EFFECT.

15 NEW SECTION. Section 45. Codification instructions.

16 (1) [Sections 1 through 20 AND 37 THROUGH 44] are intended
 17 to be codified as an integral part of Title 50, and the
 18 provisions of Title 50 apply to [sections 1 through 20 AND
 19 37 THROUGH 44].

20 (2) [Sections 22 through 36] are intended to be
 21 codified as an integral part of Title 33, and the provisions
 22 of Title 33 apply to [sections 22 through 36].

23 NEW SECTION. SECTION 46. SEVERABILITY. IF A PART OF
 24 [THIS ACT] IS INVALID, ALL VALID PARTS THAT ARE SEVERABLE
 25 FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS

1 ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART
 2 REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE
 3 SEVERABLE FROM THE INVALID APPLICATIONS.

4 NEW SECTION. Section 47. Effective dates. (1)
 5 [Sections 1 through 20, 27, 37, AND 44 THROUGH 46 and this
 6 section] are effective on passage and approval.

7 (2) [Section 21] is effective July 1, 1996.

8 (3) [Sections 22 through 28, 35, AND 36] are effective
 9 January 1, 1994.

10 (4) [SECTIONS 30 THROUGH 34] ARE EFFECTIVE JULY 1,
 11 1993.

-End-